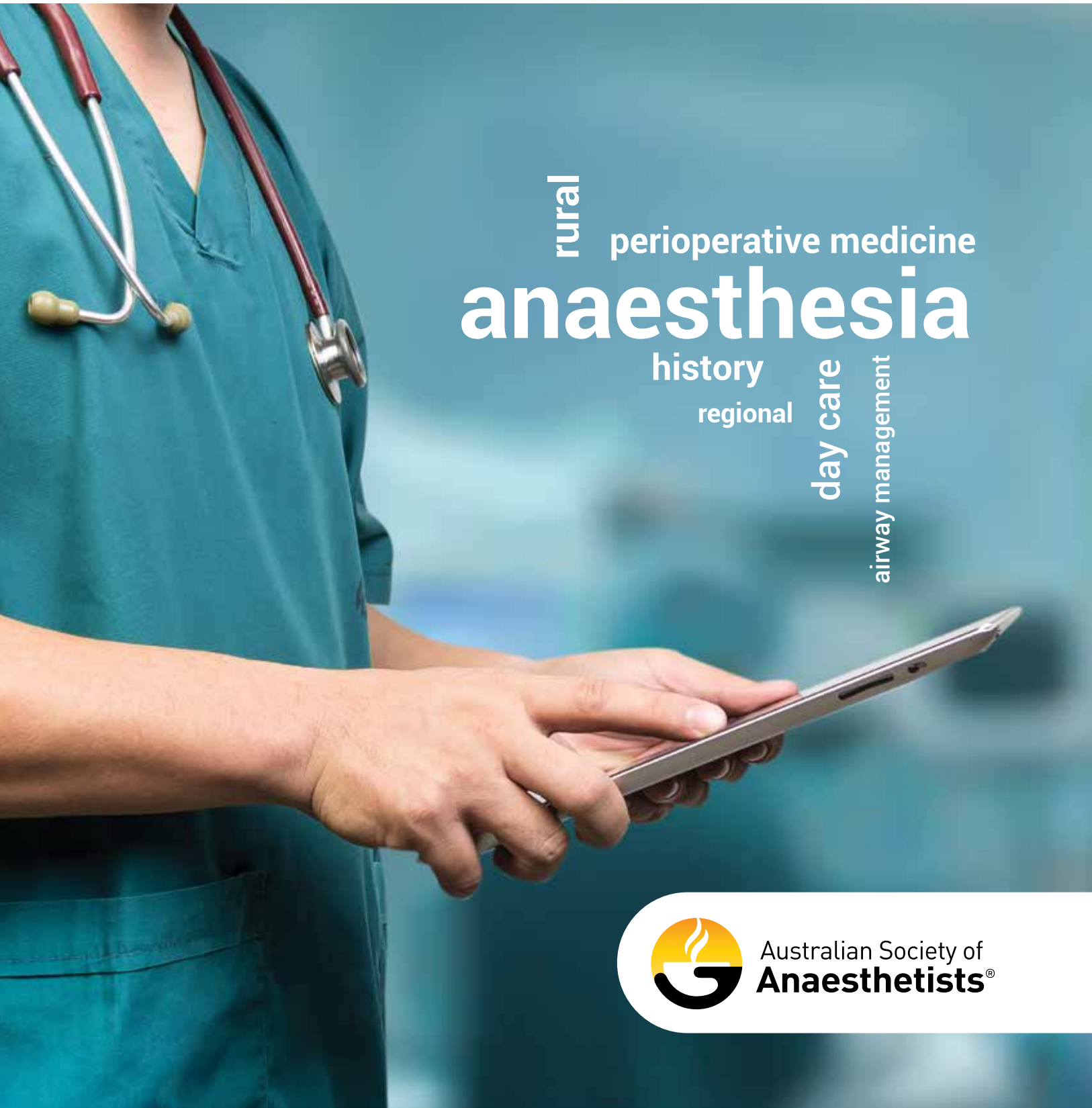
AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • SEPTEMBER 2024



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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The Australian Society of Anaesthetists (ASA) exists to support, represent, and educate Australian anaesthetists to protect the status, independence, and best interests of Australian anaesthetists and to ensure the safest possible anaesthesia for the community.

LETTERS TO AUSTRALIAN ANAESTHETIST:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email editor@asa.org.au to submit your letter or to contribute.

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Contents

Would you like to contribute to the next issue?

If you would like to contribute a feature or lifestyle piece for the December 2024 edition of Australian Anaesthetist, the following deadlines apply:

- Intention to contribute must be emailed by 18 October 2024
- Final article is due no later than 25 October 2024

Please email the editor at editor@asa.org.au. Image and manuscript specifications can be provided upon request.

FROM THE ASA PRESIDENT

DR MARK SINCLAIR
PRESIDENT

BY THE TIME OF PUBLICATION OF THIS EDITION OF *AUSTRALIAN ANAESTHETIST*, OUR 'ROUNDTABLE' MEETING AT PARLIAMENT HOUSE, CANBERRA, WILL HAVE BEEN HELD. MEMBERS OF PARLIAMENT AND SENATORS FROM VARIOUS PARTIES ACCEPTED OUR INVITATION. REPRESENTATIVES OF ANZCA, AMA, AND THE COLLEGES OF SURGEONS, O&G, AND RURAL AND REMOTE MEDICINE ALSO ACCEPTED, AS DID REPRESENTATIVES OF THE CONSUMERS' HEALTH FORUM AND DEPARTMENT OF HEALTH AND AGED CARE. THE MAIN FOCUS OF THE MEETING WAS TO DISCUSS FUTURE MEDICAL WORKFORCE NEEDS, AND THE REPORT COMMISSIONED BY THE ASA ON THE FUTURE WORKFORCE NEEDS FOR ANAESTHESIA (WITH THE ASSISTANCE OF THE HEALTH CONSULT GROUP, WWW.HEALTHCONSULT.COM.AU) IS AN IMPORTANT ASPECT OF OUR ONGOING WORK IN THIS AREA.

We are clearly facing shortages of personnel in our specialty, as indeed are other medical and allied health specialties. As members will be aware, governments at both federal and state level have certain ideas as to how to handle the issue.

The Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners, performed by Ms Robyn Kruk AO (more commonly known as the Kruk report) has made a series of recommendations on how to recruit and employ more international medical graduates (IMGs) more efficiently, particularly in specialties identified as being of priority for action by the end of 2024 – anaesthesia, obstetrics and gynaecology, psychiatry, and general practice.

However, it is not only Australia that is facing shortages. Many countries, including first world nations such as the UK, USA, Canada and New Zealand, also have workforce issues. Despite our own challenges, we are actually better off than most countries. Encouraging doctors to leave these jurisdictions and come here raises clear ethical concerns.

However, it is not only Australia that is facing shortages. Many countries, including first world nations such as the UK, USA, Canada and New Zealand, also have workforce issues. Despite our own challenges, we are actually better off than most countries.

As always, however, the primary concerns are patient safety and quality of care. To this end, it is essential that the Australian and New Zealand College of Anaesthetists (ANZCA) takes the lead on assessment of the skills and qualifications of IMGs. The Australian Health Practitioner Regulation Agency (AHPRA) and government departments of health at federal and state level must be involved, but it is ANZCA which has the assessment expertise, not government officials. The ASA will continue to support ANZCA in this regard.

Members have also no doubt seen the email update from ANZCA which lists the various bodies involved in workforce reviews, and notes that these bodies often lack cross-communication. Fortunately, ANZCA is now one of five Colleges represented on the Medical Workforce Advisory Collaboration (AMWAC) and we look forward to seeing the output from this group.

We are also seeing initiatives aimed at expanding the scope of practice of other health care professionals such as registered nurses and physician assistants into perioperative care, including roles such as 'sedationists'. This is an ever-changing arena and further developments may well have taken place by the time of publication of this edition.

ANZCA President Prof David Story joined me, ASA CEO Matt Fisher and ASA Policy and Public Affairs Manager Bernard Rupasinghe in a meeting with representatives of the Australian College of Peri-Anaesthesia Nursing (ACPAN) and the Gastroenterology Nurses College of Australia (GENCA) in late July. ACPAN President A/Prof. Vera Meeusen has herself worked as a nurse anaesthetist in Europe. She assured attendees that any model involving sedation nurses (a term they prefer to 'nurse sedationist') was not aimed at independence of nurse practitioners, but rather, a fully supervised model, as in Europe. There is no aim for a USA-style system. There is also no aim to take such initiatives into the private sector.

This was good to hear, but a couple of issues remain. Initially, the USA system for nurse anesthetists and physician assistants also involved doctor-supervised models. However, over time, these practitioners have sought fully independent practice rights and these have been granted in numerous USA states, across various health care specialties. They claim to be as good or better than fully-trained medical specialists, although the only evidence for safety and quality comes from studies involving supervised models. There is also no evidence to back claims of better access to rural and underserved patient populations, or for cost savings. We must therefore remain vigilant.

Given our 90th year has been packed with activities, if you can't get to the NSC in Darwin, there are various activities been convened through the State and Territory sections which you may be able to attend. Our new website also provides you with an opportunity to engage with us and tailor your interests, so I encourage you to sign in and explore.

Dr Mark Sinclair

MB BS, GAICD, FANZCA

DR MATTHEW FISHER
CHIEF EXECUTIVE OFFICER

FROM THE CEO

IN OUR 90TH YEAR WE CONTINUE TO DRAW ON THE SUCCESSES AND LEARNINGS FROM THE PAST TO FOCUS ON OUR PERFORMANCE INTO THE FUTURE. AT THE ASA WE DRAW ON THE STRENGTHS OF OUR EXISTING NETWORKS, SUCH AS THE SPECIAL INTEREST GROUPS (THE THEME OF THIS EDITION) WHICH ARE PART OF THE TRI-PARTITE ACE AGREEMENT WITH NZSA AND ANZCA, WHILST WE FORGE NEW AND DEEPER NETWORKS WITH OTHERS IN OUR ENVIRONMENT.

This has been guided by our Strategic Directions as highlighted in the June edition which represent what the Board of the ASA is seeking from the operations of the ASA. Certainly, a focus has been on the influencing capability of the ASA which takes time to form relationships and anchor it into business as usual. Two highlights to date were the celebration at the National Museum of Australia and the Parliamentary Roundtable, both in Canberra. At each event, there was broad representation of politicians from both the House of Representatives and the Senate, senior people from Department of Health and Ageing, consumer representatives, other medical groups and of course, the ASA.

At the Roundtable, hosted by Dr Mike Freelander (Labor MP) and Dr David Gillespie (Liberal MP), we were able to start telling the "story" of anaesthetists and the ASA through themes such as why Australian anaesthetists are viewed as world leading, where anaesthetists work and why this gives insight into hospital performance, what the public perception is and how we want to lead this, and what our workforce modelling has told us. On this last point, we affirmed that the demand for anaesthetic services will increase, that there is an existing shortage of anaesthetists as detailed in the Kruk review, that the extent and depth of shortage can be remedied whilst avoiding an over-reaction. Such levers would risk quality and safety. The solution rests with coordination and commitment of funding at Federal, State and Territory levels given patients and the public see it as one system. A key message was that anaesthetists make what they (you) do look easier than what it is and are there for the crucial decisions that keep patients safe. This public interest point needs recognition and not to be lost in any decision for change.

In our July submission to the Medical Board of Australia in relation to the draft revised Registration standard: specialist registration, we made an opening comment consistent with the public interest. We stated that "The ASA affirms its support for the Australian and New Zealand College of Anaesthetists (ANZCA) role and guidance with regards to specialist international medical graduate (SIMG) registration and their very sound work on SIMG assessment to date. We support its function and insights as to how to move into the future. Australia currently has a specialist healthcare workforce comprising both locally trained and overseas trained specialists. Our overseas trained specialist workforce is highly valued for the work they perform, and for the skills and experience they bring to providing healthcare for all Australians". The ASA affirms its support of registered specialist anaesthetists, and this is a core Object of our work in both the interests of the specialty and the public it serves.

Our closing comment in the submission was based on our workforce modelling: "Given that training places are determined by State and Territory Health departments and there are disparate approaches to engage and support anaesthetists working in the public sector (awards and conditions, morbidity & mortality review processes, workplace health & safety considerations), the ASA suggests that there needs to be greater consideration of what the structure, roles and sustainability of the public/private workforce is to ensure high standards of care are maintained. The public sector workforce contributes not only direct services but research and training capability that maintains the quality care and innovations expected. This "core" business is supported by joint appointments (VMOs) and relies on the professional goodwill and ethos of our highly trained specialists. If standards are changed to expedite a "volume of practitioners" this needs to be done so with deep consideration of cultural integration and understanding of the Australian healthcare system and expectation of the Australian public to ensure equity in timely and high-standard care".

As we ready ourselves for our Darwin NSC 24, we look forward to engaging with you and enlarging the footprint of the ASA on your and the Australian public's behalf.

This affirms our Vision for the specialty and the ASA which states "Anaesthetists practising optimally on behalf of patients, their safety and the health system" and that we progress to being "An exemplary society of anaesthetists advocating for the specialty, patients, patient safety and an accessible, equitable health system".

Matthew Fisher

PhD DHlthSt (honoris causa)

Contact

Please forward all enquiries or correspondence to Sue Donovan at: sdonovan@asa.org.au or call the ASA office on: 02 8556 9700

Get involved in your ASA ...

Seeking new members

The Communications Committee is seeking new members who are passionate about effective communication. If you are interested in enhancing the communication strategies of the ASA please send an email to Senior Communications Coordinator, Brittney Beynon bbeynon@asa.org.au with your expression of interest.

Passionate about helping the ASA advance its cause?

Find out more about the Society's various committees and groups that work alongside the ASA to help support, represent and educate anaesthetists.

To inquire about how you can contribute and express your interest in being involved, email the Operations Manager, Suzanne Bowyer at committees@asa.org.au

- **Economic Advisory Committee**
- **Professional Issues Advisory Committee**
- **Public Practice Advisory Committee**
- **Editorial Board of Anaesthesia & Intensive Care**
- **Overseas Development and Education Committee**
- **Trainee Members Group Committee**
- **General Practitioner Anaesthetists Group**
- **National Scientific Congress Committees**
- **Communications Committee**
- **Retired Anaesthetists Group**
- **The History of Anaesthesia Library, Museum and Archives Committee**
- **ASA State Committees of Management**
- **Wellbeing Advocates Committee**

HISTORY OF SPECIAL INTEREST GROUPS (SIGS)

MY PARTICULAR INTEREST IN SPECIAL INTEREST GROUPS GOES BACK TO MY EARLY INVOLVEMENT WITH THE GEOFFREY KAYE MUSEUM COLLECTION, WHEN I WAS ENCOURAGED BY KESTER BROWN TO TAKE AN INTEREST. AT THE TIME, THE COLLECTION WAS LANGUISHING UNLOVED IN THE ATTIC OF THE ROYAL AUSTRALASIAN COLLEGE OF SURGEONS (RACS), AND APART FROM A SMALL DISPLAY IN THE "FACULTY EDUCATION ROOM" IN THE BASEMENT, NO-ONE HAD TAKEN AN INTEREST IN IT SINCE KEVIN MCCAUL HAD GIVEN UP HIS CURATORSHIP DUE TO LACK OF SUPPORT FROM THE COUNCIL AND BOARD.

Knowing my interest in things mechanical, Kester got me involved, and ultimately, Robin Smallwood, who was Dean of the Faculty at the time, and who was also very keen for the collection to be properly cared for, had me appointed by the Board as Honorary Curator in early 1987.

I then set about attempting to sort and catalogue the collection, engaging help from registrars from RCH and others, both local and overseas. I was very fortunate to find an enthusiastic budding historian in Chris Ball, who started helping me while still a registrar. In 1989, I proposed to the Faculty Board that she be appointed officially as the Honorary Assistant Curator, and she and I continued to develop the collection into the Geoffrey Kaye Museum, as it is known today.

As Honorary Curator, I was appointed to the Archives Committee of the RACS in 1988, along with Gwen Wilson, and remained on that committee until 1995, after ANZCA was formed in 1992. I was also treasurer of the Victorian Faculty/ASA Continuing Education Committee from 1980 to 1988, and this points to my other interest at the time, Continuing Education.

In 1995, I was elected to the Council of ANZCA, and in the following year I was also elected as Vice President of the ASA. This gave me an opportunity to try and enhance the relationship between the two organisations.

One of my objectives was to establish a Special Interest Group in Anaesthesia History (there being very active societies in most overseas countries).

There was a problem (or several). A few SIGs had been established already. All, except one, were under the auspices of ANZCA, and only Fellows of ANZCA could be members of these SIGs. This was a major problem for me, as there were serious historians in both the ASA and the NZSA who were not at that time, Fellows of ANZCA. I was also keen for the history SIG to be able to engage non-anaesthetists as members, or at least as associate members. I could see that this was potentially an issue for other prospective SIGs as well.

The only SIG that was independent of ANZCA at the time, was the obstetric group, and it had encountered some difficulties in operation.

Knowing my interest in continuing education, I was appointed by College Council to chair the Continuing Education Committee. At the time there was a loose association between the College (and the Faculty before it), the ASA and CECANZ (Continuing Education Committee of Anaesthetists of New Zealand, formed in 1982), that was convened by Kester Brown and met twice a year. (CECANZ was a very active organisation, holding major meetings each year in New Zealand, under the auspices of the NZSA).

I felt that it was important for Special Interest Groups of all interests, to be open and accessible to anyone who could contribute or benefit from membership. I then re-invented Kester's loose association, and established it as the Anaesthesia Continuing Education Co-ordinating Committee (ACECC), under the joint oversight of ANZCA, the ASA, and the NZSA (CECANZ). This was agreed to by all three organisations at Council/Board level.

I then set about drafting a generic constitutional model for SIGs, that would exist under the tripartite umbrella of the three parent organisations.

The other primary stimulus for this approach was the likelihood that with increasing subspecialty interest, new SIGs were likely to form independently of any of the three parent organisations.

The generic model allowed for Fellows or members of the three organisations to be eligible to join without fee, and for associate members to join with or without a fee to be determined by the SIG executive. There was to be regular rotation of chairmanship, and the SIG could choose which organisation would provide secretarial support. There were also obligations on the SIGs to plan and report activities to avoid clashes of meetings, and for the parent organisations to provide opportunities for each SIG to be involved in their major national conferences.

I was greatly assisted in this endeavour by the then President of ANZCA, Richard Walsh. Richard had previously been Federal Secretary of the ASA, so was well versed in some of the issues involved.

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The obstetric SIG eventually came on board as a SIG under the tripartite arrangement, and all new SIGs have done likewise, except for one. The Paediatric SIG, or SPANZA decided to establish independently. Although I had been one of the founding group in establishing the paediatric subspecialty organisation, the prevailing wisdom of the group at the time was to remain independent, so as to be more easily recognised on an equal footing by other international paediatric anaesthesia societies.

I continued as Chair of ACECC from 1997 until 2007. ACECC eventually became ACE, and I believe that the system has served the specialty well. The SIGs are freely available to everyone, with effective coordination and oversight, the costs being shared between the parent organisations. We have avoided the unfettered proliferation of independent subspecialty societies that has occurred overseas.

Dr Rod Westhorpe

HISTORY OF ANAESTHESIA SPECIAL INTEREST GROUP

History is important because it provides lessons for the future

I am writing this from Alaska, near Mt. Denali. The National Park Service's attitude toward trash on Denali reflects many people's views of history:

"...the delicate balance between environmental protection and historical preservation. While climbers must pack out what they pack in, they leave alone anything abandoned by people who climbed half a century before them. Articles left behind by people more than 50 years ago are considered historic and should be left untouched. These objects and their surroundings tell the stories of those who have come before, stories that might be lost without the artefacts."

These words are similar to words of J. Alfred Lee, a humble historian of anaesthesia, who wrote:

"When does history begin? Perhaps the 50-year rule is sound. I would like to describe some of the practical details of clinical anaesthesia which I experienced more than 60 years ago at the teaching hospitals of Newcastle-upon-Tyne where I qualified in 1927; ..."

But Lee goes on to:

".... emphasise three simple lessons born out of experience?

(1) When recalled today our methods may appear to have been unsatisfactory, but were not so regarded at the time. Anaesthetists managed to give reasonable anaesthetics for the operations then in vogue, including thyroidectomies, sub-mucous resections of the nasal septum, caesarean sections, colectomies, hysterectomies and cholecystectomies, but of course the cranial cavity and the chest were seldom opened.

(2) History teaches us that our successors 60 years hence will be just as horrified when they reflect on the methods used today as we are, looking back at the 1920s from the vantage point of the 1980s. Methods extolled today will be despised tomorrow.

(3) History also teaches that the full paraphernalia involved in the application of aseptic methods in surgery and the use of sophisticated apparatus for the administration of general anaesthesia are both admirable, but that good work can be performed by adopting antiseptic methods of sterilisation and the open drop method of general anaesthesia, using a volatile agent. Let us hope that conditions beyond our control never make the use of such outmoded but practical and useful techniques again necessary."[2]

So it is important to get the facts right by the preservation of artefacts, but it is also important to learn lessons.

When did anaesthesia start and for whom was it important?

General anaesthesia, as we know it, did not exist before 1846, but 'pain relief' for surgery was used. There is evidence of compression anaesthesia in Roman times and records of painless surgery in Islamic texts of the 11th and 12th centuries. Hanaoka Seishū (a surgeon in Japan) started to use orally administered herbs to induce coma in patients before operating in 1804. In 1842, Crawford Long used ether to ablate pain for surgical procedures he performed, but did not publicise this until after William Morton gave a public demonstration in 1846 which showed that the supervised

It is simplistic to suggest there is no history of anaesthesia prior to 1846. Prevention and treatment of pain has always been important to people (and animals) suffering with childbirth, injuries, or surgery. Patients and surgeons have always been central to this history.

inhalation of a volatile substance could prevent awareness of pain during surgery. In the same year Oliver Wendell Holmes was moved to write to Morton:

"Everybody wants to have a hand in a great discovery. All I will do is to give a hint or two as to names - or the name - to be applied to the state produced and the agent. The state should, I think, be called "Anaesthesia." This signifies insensibility - more particularly ... to objects of touch."

It is simplistic to suggest there is no history of anaesthesia prior to 1846. Prevention and treatment of pain has always been important to people (and animals) suffering with childbirth, injuries, or surgery. Patients and surgeons have always been central to this history.

It is important history is correctly recorded and interpreted

Morton attempted to conceal the identity of the volatile substance he used. In fact he attempted to market it for commercial gain, but it was immediately identified as ether. The news of its use spread to the 'Old World' and there was rapid embrace of ether anaesthesia around the world. William Pugh, in Launceston, Tasmania, read of the development in a copy of the Illustrated London News, brought by ship from Great Britain. He was probably the first Australian to use ether anaesthesia for surgery (on 7th June 1847).

William Russ Pugh monument, Australia.

Chloroform as an alternative volatile agent for prevention of pain was proposed in Edinburgh by James Simpson in 1847. There ensued debate over many years about the relative merits of using ether, chloroform, or one of many other agents, or even combinations of agents.

Anaesthetists are best placed to collect and interpret the history of anaesthesia

By the 1930s the number of doctors with a special interest in anaesthesia was increasing. Anaesthetists from Australia were travelling by boat to the United Kingdom and to the United States of America to learn new techniques. They were returning, also inspired by the likes of Henry Featherstone who became the first President of the Association of Anaesthetists of Great Britain and Ireland "to raise the status of his fellow anaesthetists among the medical profession, and in doing so to improve patient safety."

In the 1930s, around 90 years after the introduction of ether, anaesthetists recognised that narrative history of anaesthesia was an effective way to highlight the importance of skilled administration of anaesthesia, raise the status of anaesthetists, and improve patient safety.

Many of these anaesthetists went on to found anaesthesia sections of their British Medical Association branches, anaesthesia specialty associations (the ASA in 1934 and NZSA in 1948), and then in 1952, the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

Many organisations are involved in the history of anaesthesia

This year we celebrate 90 years of the Australian Society of Anaesthetists. Lessons from history have made anaesthesia multiple times safer than in 1846. Let's keep it that way.

In the 1930s, around 90 years after the introduction of ether, anaesthetists recognised that narrative history of anaesthesia was an effective way to highlight the importance of skilled administration of anaesthesia, raise the status of anaesthetists, and improve patient safety.

The ASA has three facilities dedicated to history: The Harry Daly Museum, the Richard Bailey Library, and the ASA Archive. The History of Anaesthesia Library, Museum and Archives Committee (HALMA), which formed in June 1996, is the steering committee for these facilities. HALMA membership is restricted to ASA members.

The Australian and New Zealand College of Anaesthetists (ANZCA) has the Geoffrey Kaye Museum Collection (GKMC). The GKMC was passed to ANZCA from the Faculty of Anaesthetists of the RACS. The GKMC was established by Kaye as a teaching tool. Kevin McCaul was for many years curator of the Kaye collection in the hands of the Faculty. After McCaul, there was a substantial lapse in management of the collection until 1987 when Kester Brown and Robin Smallwood induced Rod Westhorpe to accept appointment by the Board as Honorary Curator. Rod engaged local and international registrars from the Royal Children's Hospital, Melbourne and others to help sort and catalogue the collection. One of these registrars was Chris Ball, who in 1989 was appointed as the Honorary Assistant Curator by the Faculty Board.

The Royal Australasian College of Surgeons also has an Archives Committee. Dr Gwen Wilson was on that committee, and Rod Westhorpe was on that committee from 1988 until 1995 (after ANZCA was formed in 1992).

The History of Anaesthesia Special Interest Group is a partnership between ANZCA, the ASA and the New Zealand Society of Anaesthetists. This SIG was established in 2000 and members are from Australia and New Zealand. Membership is not restricted to members of ANZCA, the ASA (unlike HALMA), the NZSA, or medical practitioners.

The primary concern of the HA SIG is to research and present the history of anaesthesia.

This includes:

- facilitating content for the ASA National Scientific Conference, ANZCA's Annual Scientific Meeting, and NZSA's Annual Scientific Meeting
- assisting trainee and new Fellow members in developing their skills and interest in historical research
- coordinating and facilitating historical anaesthesia research for the membership and speciality.

But more than that, we recognise that the history of anaesthesia is not the property of any group. History is an easy way to engage with our communities with the message that anaesthesia in the past has not been without risk. I invite you to show your commitment to the future of our specialty by making the HA SIG one of your SIGs.

Conclusion

We forget the past at our peril. While everyone is involved in remembering the history of anaesthesia, we as anaesthetists are better placed to ensure the remembrance is accurate and correctly interpreted. Making the HA SIG one of your SIGs is an easy way to show your commitment to the history of anaesthesia and to help you engage with every patient. At the September ASA NSC in Darwin the HA SIG will be exploring the history of women in anaesthesia. Join us.

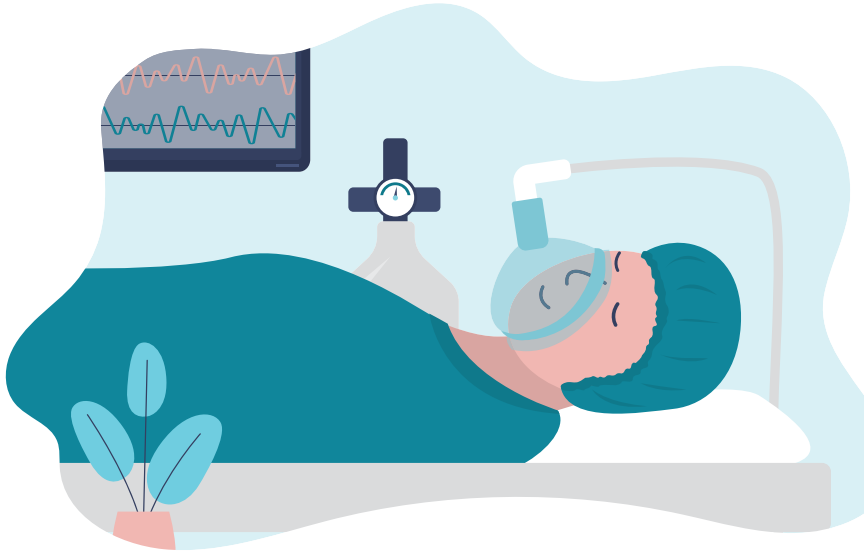
Dr Andrew Walpole
Chair of History of Anaesthesia Special Interest Group, Australia

References

1. Denali National Park and Preserve https://www.nps.gov/dena/index.htm
2. The History of Anaesthesia edited by R S Atkinson and T B Boulton 1989 pp 12 (https://www.gbv.de/dms/bs/toc/018120733.pdf) accessed 2024

AIRWAY MANAGEMENT SPECIAL INTEREST GROUP

OVER THE PAST 12 MONTHS THE AIRWAY SIG HAS CONTINUED TO ACTIVELY SUPPORT THE AIRWAY MANAGEMENT AGENDA IN AUSTRALIA AND AOTEAROA NEW ZEALAND, AND SOME OF THE ACTIVITIES WE HAVE BEEN ENGAGED IN ARE OUTLINED BELOW.



The group will be shortly undertaking a recruitment drive for members via the ACE events bulletin, and from the membership will be seeking to fill a number of positions on the Executive which will include the appointment of a new Chair and Deputy Chair. If you are active in airway management either via education, research, quality assurance/review of incidents or in providing care to head and neck patients with difficult airways or who are having airway surgery we would encourage you to join here https://www.anzca.edu.au/resources/forms/sig-forms/sig-application-form.aspx.

Difficult Airway Alert Form

Communication about a previous difficult airway is key to guiding future airway management. A point-of-care patient protective airway database remains a long way from clinical use. As a first step, standardisation of the information collected on encountering a difficult airway and importantly when an alert should be generated has been recognised. The Difficult Airway Alert is an initiative of the Queensland Health Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet). The work has supported the development of agreed definitions for bag mask ventilation, supraglottic airway ventilation and tracheal intubation. In addition, the working group has made additions to the SNOMED clinical terms system to allow for difficult airway information to be more accurately reflected in electronic health records. Both the ASA and ANZCA have endorsed the form and encourage its use throughout Australia to standardise communication surrounding this important clinical event. The form can be easily rebranded for each health district and a digital template of the form is also available. To rebrand the form, contact the SWAPnet coordinator via email, swapnet@health.qld.gov.au and more information about the form and the background document are available here https://acecc.org.au/special-interest-groups/airway-management/.

The SIG is continuing to promote uptake of this documentation.

Support for Key Airway Guidelines

The SIG has leant its support to the guidelines published by the PUMA group on the Prevention of unrecognised oesophageal intubation. Find out more here https://www.universalairway.org/puoi.

The guideline is extremely well researched and written, and speaks in a clinically relevant way to how complex an unrecognised oesophageal intubation can be in stressful clinical environments. It uses images, cases and cognitive aids which assist interpretation and translation of knowledge directly into clinical practice. It is of critical importance to our entire community to remain aware of contemporary guidance on how to safely manage airways and prevent patient harm. There is strong consensus support to promote these guidelines from the Airway SIG executive.

Airway Sessions and SIG meeting

The Airway SIG meeting supported the ASA conference held in Melbourne in October 2023 with a standalone conference ahead of the main ASA event. Polished sessions from many airway experts from within Australia and the UK included Dr Imran Ahmad, DAS Chair, speaking on advanced techniques for those with difficult airways and Dr Andy Higgs talking to his experience of airway management in the critical care setting. The ANZCA ASM this year had two international speakers from the UK, Dr Helen Iliff and Dr Emilie Hoogenboom, alongside two local enthusiasts speaking to their recent publications. Dr Scott Douglas shared the RPA's experience of cannulas as front of neck rescue devices and Associate Professor Paul Forrest on the role of ECMO to support airway procedures. Another high-quality line up is in place for the upcoming airway session at the ASA National Scientific Congress in Darwin and we'd love for you to join us.

The session details are:

Saturday September 7
10:15am-11:45am

Airway SIG
Chair: Dr Linda Beckmann
Oxygenation, time to switch
Prof Anil Patel
Airway management for the physiologically difficult airway - new clinical guidelines
A/Prof David Brewster
Hyperangulated videolaryngoscopy in difficult airway management, perspectives from a UK head and neck fellowship
Dr Rosalyn Boyd
Prophylactic cannula cricothyroidotomy and the Rapid O2 - simplifying the complex airway
Dr Sivan Wexler

Airway Leads

The SIG continues to support the Airway Leads network across Australia and Aotearoa New Zealand.

The role of the Airway Lead is broadly:

- Local airway education and training
- Implementation of best practice from guidelines (Addressing the safety gap between ideal and actual practice)
- Ensuring appropriate and standardised airway equipment (not just within the theatre complexes but ideally all areas where airway management occurs)
- To collaborate with intensive care and emergency departments
- Overseeing audits
- Reviewing and supporting people after adverse airway outcomes.
- Supporting the standardised approach to airway alert notification.

But more than this, the Airway Lead is the person with the interest and enthusiasm who is approachable and sensible and acts as the go to person for all things airway. Much of the role, rather than being prescriptive, is quite organic in nature. Anaesthetic assistants may come to the Lead when out of certain types of equipment to figure out appropriate replacements and liaise about equipment trials. People reach out to Leads to debrief airway events that were difficult or traumatic. The person in the role has to be up-to-date, but can lean on the group of leads for help on that front. More important is that they have the time, head space, approachability, and eagerness for the role. You can find out more about Airway Leads, including if your hospital already has a lead or to express your interest in becoming one here https://www.anzca.edu.au/fellowship/anaesthesia-continuing-education-(1)/airway-management-special-interest-group/airway-leads-networks.

CICO training and recognition of instructors

At this year's ANZCA ASM the SIG supported the training of a record 380 participants in their CICO emergency response workshops in the course of one day. Prior to this the SIG successfully advocated for the reinstatement of emergency response sign off for instructors of all emergency response activities.

Dr Linda Beckmann
Chair of Airway Special Interest Group

DAY CARE ANAESTHESIA SPECIAL INTEREST GROUP

IN 2010 I RECEIVED AN EMAIL FROM GREG DEACON, AN OFFICE-BEARER AT THE ASA, WHO HAD CURATED THE IDEA OF SPECIAL INTEREST GROUPS WHICH HAD BECOME AN IMPORTANT CLASSIFICATION OF MEMBERS' PARTICULAR INTERESTS. THIS EMAIL BORE AN ANGRY YET DISAPPOINTED TONE. THE DAY CARE ANAESTHESIA SIG WAS IN DANGER OF BEING DISBANDED AS IT COULD NOT FIND AN EXECUTIVE, MUCH LESS A CHAIRMAN. AS A MORE-OR- LESS RECENT CHAIR (JUST TEN YEARS SINCE) OF THE VICTORIAN BRANCH OF THE ASA, A PREVIOUS PRESIDENT OF AMAVIC AND AN EVEN MORE PREVIOUS CHAIR OF THE RACS FACULTY VICTORIAN REGIONAL COMMITTEE, I FELT THAT I SHOULD OFFER MY SERVICES, AT LEAST AS AN EXECUTIVE MEMBER. I HAD SEMI-RETIRED, MOVED TO THE SUNSHINE COAST, AND WAS HELPING OUT AND FILLING SESSIONS WHERE REQUESTED.

The former Chair had resigned as he had cancer. He then called upon a colleague, who almost immediately was diagnosed with cancer and rejected the office. Subsequently and for some time, the Executive had not met, and its members were seemingly not interested.

The SIG had a large membership of 1189 for which no extra subscription was required. Its affairs were covered within membership subs and conference payments.

Membership and response

Within a short time an Executive was formed from alarmed and interested members, a teleconference held, and I found myself elected Chair unopposed. History repeated itself a few years later when I developed cancer so called the person most likely to want my job to find that an ultrasound of their gallbladder had demonstrated a small cancer in their kidney! A common result nowadays. Long story short I am still Chair but we have had an excellent and hardworking group of state reps, all of whom have convened at least one ASM or NSC session with aplomb.

Our sessions have been quite diverse in respect of gender, knowledge, and variety; but all very well attended. The Executive can always come up with a new topic as there are many - from new techniques, new drugs, medicolegal issues, older patients with multiple comorbidities, frailty, cognition, and outcomes, important outcomes which we never used to hear about until we next met the concerned surgeon or proceduralist. Next-day phone calls were unproductive; made by the PACU nurses early in the day before they were over-run with patients, and met all too often with no answer. Very little additional success from calls later in the day. Best rate of success was 40 to 42%, only on a few days.

Looking into outcomes

From the time that I became Chair we discussed the matter of confirming the fact that the day patient was well and recovering. We needed the patient to answer a questionnaire. We needed to limit the number of questions, classically no more than 15. We needed measures of patient-reported observations (PROMs) and their experiences (PREMs).

The Executive can always come up with a new topic as there are many - from new techniques, new drugs, medicolegal issues, older patients with multiple comorbidities, frailty, cognition, and outcomes, important outcomes which we never used to hear about until we next met the concerned surgeon or proceduralist.

I wrote an article for 'Australian Anaesthetist', expressing my concern that we had the questions, now we needed a method of promulgation and response. I had barely finished reading my copy of the printed version when I received a response from Dr John Sestan, a Newcastle anaesthetist. Not only did he have the answer, but the software platform on which it could be built. The rest was, as they say, history. Our collaboration with John has been outstanding.

The Day Care Outcomes Recording (DayCOR) Registry has just passed six years surveying patients, 24 hours post discharge. Our response rate is, we believe, phenomenal: 86% overall and almost 90% from the parents of children anaesthetised.

The task now is to increase the usage, especially from all those jurisdictional health departments who thought it was excellent but "did not have the money". There has been much interest from the private sector who also "had no money", "were improving their digital data management" or get this one: "We already have enough Registries" (Healthscope).

This is not the time for another exposition of DayCOR but you can visit the website: www.daycorregistry.com.au

The Australian Commission on Safety and Quality in Health Care has recognised DayCOR as a Clinical Quality Registry-ARCR-203.

Other activities

We believe it important to discuss medicolegal issues regularly and Avant have always been available to contribute to these topics.

I must mention all the work done by our state reps in convening sessions.

Sanjeev Sawhney, a laconic but hard-working anaesthetist from Queensland, had presented an excellent paper on the management of the drug-addicted patient at a previous meeting. When the Queensland executive vacancy occurred he was the enthusiastic acceptor of the nomination. He then convened an excellent session in the midst of COVID with 'Frailty' the main topic. The session reinforced the necessity for geriatric and other assessment, not only for the day procedure but for any future care, especially major surgery, when early and active prehabilitation provides an outcome equal to the non-frail person.

The Clinical Frailty Scale, developed by Dr Ken Rockwood, the Canadian geriatrician has, with his colleagues, provided an excellent scale for simple and rapid assessment - I am sure that you use it regularly.

Shravani Gupta from NSW provided an excellent review of management of OSA with three colleagues at an ASM session in Sydney some years ago. Her talentedly decorated slides emphasised the content. She has become a keen and thoughtful participant in executive activities.

Niki Tan from Epworth Hospital in Melbourne was an early supporter of DayCOR, presenting, in her stylish way, the first 12 months of DayCOR at the ANZCA ASM in Kuala Lumpur in 2019. Niki has proven to be a great supporter of DayCOR from these earliest days, suggesting improvements and initiating, with John Sestan's brilliant software, the automatic presentation of some of the data directly into the survey form from the digital hospital record.

Tomoko Hara has curated several sessions at our New Zealand ANZCA meetings. Her mature knowledgeable approach to everything anaesthetic has often provided the simple solution for a position paper statement.

Leena Nagappan has also supported the DayCOR Registry by presenting it to Health Department officials in Perth. She has curated and convened sessions in Perth, and in Penang at the height of the COVID pandemic. She provides valuable opinions at our meetings having a wide experience in perioperative care as well. Her husband, Brian Hue, conducts day care anaesthesia for total knee replacement at Joondalup Hospital. We are all getting close to utilising this technique now.

Shravani and Leena are talented contributors to Instagram too, Shravani with her detailed artwork and Leena with her pics of designer coffees and unique café meals.

Reg Edward from Gippsland (India, UK and Canada before that) is the latest member of our Executive, organising our investigation into heavy-prilocaine spinals for appropriate day cases. Previously running a day procedure centre in Hull and an ambulatory centre in Toronto, he is a valuable recruit for our executive.

Our new venture is into the world of 'mobile anaesthesia' or, as some would put it, dental sedation. After 50 years absence this field is growing in popularity due to the lack of hospital facilities for dental procedures. We need to support these colleagues in this unusual situation for most of us. Standards are being written under the guidance of David Canty, a very well-known Melbourne anaesthetist.

Dr Ken Sleeman
MB BS(Hons) FAMA FANZCA
Consultant Anaesthetist
Chair of Anaesthesia Continuing Education Day Care Anaesthesia Special Interest Group
Chair and Clinical Director of DayCOR Registry II Ltd

THE PERIOPERATIVE MEDICINE SPECIAL INTEREST GROUP

Where Are We Now?

From its inception, the Perioperative Medicine Special Interest Group (POM SIG) has grown to nearly 900 members from diverse specialties; including anaesthetists, intensivists, geriatricians, general physicians, surgeons and general practitioners across Australia and New Zealand. Healthcare professionals such as pharmacists, nurses, and physiotherapists can join as associate members, although current numbers suggest there is a need to reduce barriers for members of these groups to join. Over the past 14 years, the POM SIG has expanded rapidly and is recognised by various medical groups, not only in Australia and New Zealand, but worldwide. It has a long history of highly successful annual meetings, offering valuable networking opportunities across specialties and disciplines.

Where Did It All Start?

The story of POM began in Australasia, when Associate Professor Ross Kerridge introduced the perioperative system concept, including day of surgery admission and the development of preadmission clinics. Ross, often considered the grandfather of POM, has played a pivotal role in its progression since those early days in Liverpool Hospital in 1989, not just in Australia and New Zealand but globally.

ANZCA's involvement with POM commenced nearly 20 years ago when then-President Professor Michael Cousins tasked Dr. Vanessa Beavis, recent past ANZCA president, with surveying fellows about their interest in POM. In 2005, the Perioperative Task Force recommended integrating preoperative, intraoperative, and postoperative services into a single perioperative medicine service led by anaesthetists working with a multidisciplinary team to provide patient-focused, evidence-based perioperative care. The POM SIG started in 2010 as a working group of like-minded clinicians, chaired by Dr Beavis, advocating for a change in the delivery of perioperative care in response to evolving demands.

In 2011, the Royal College of Surgeons of England and the Department of Health[1] published a report highlighting that 20% of surgical patients account for 80% of perioperative complications, suggesting this high-risk group should be the target for interventions as they were the group where most gains could be made. In 2012, POM thought leaders Professors Grocott and Pearse published an editorial in the British Journal of Anaesthesia, stating, "Perioperative medicine is the future of anaesthesia, if our specialty is to thrive". [2]

That same year, the first Perioperative Medicine SIG meeting was held in Byron Bay, with just under 70 attendees. By 2019, it had become the largest POM meeting worldwide (briefly), with 550 delegates descending on Melbourne for the meeting. The COVID-19 pandemic forced a shift to a virtual meeting format in August 2020, which, despite challenges, was a major success and fostered a sense of community among perioperative enthusiasts during times of uncertainty, isolation and intermittent lockdowns.

I have had the privilege of witnessing and being part of POM's evolution in Australasia, first as an attendee of the Perioperative Medicine SIG meetings, then as a member of the executive, a convenor of the annual meetings, and finally as chair. The POM SIG was instrumental in advancing the POM agenda in the early years, bringing stakeholders from multiple specialties together to brainstorm how to address the problem of fragmented perioperative care in an increasingly complex and ageing surgical population.

By 2018, ANZCA further advanced POM by establishing the POM Steering Committee, commencing work on the Perioperative Care Framework[3], and developing the first clinical course in POM. The perioperative care framework maps the patient journey from surgery contemplation to optimal outcome. The infographic in the framework, affectionately known as the "nephron" (see fig.1)[3], is now internationally recognised across multiple craft groups as a visual representation of the novel holistic perioperative journey.

Why Is It Important?

A successful operation alone is no longer sufficient to be considered a successful perioperative outcome. Given the high quality of the intraoperative environment, the focus must turn outside of the operating theatre on improving preoperative risk assessment, optimisation, shared decision-making, and implementing perioperative risk reduction strategies to reduce preventable

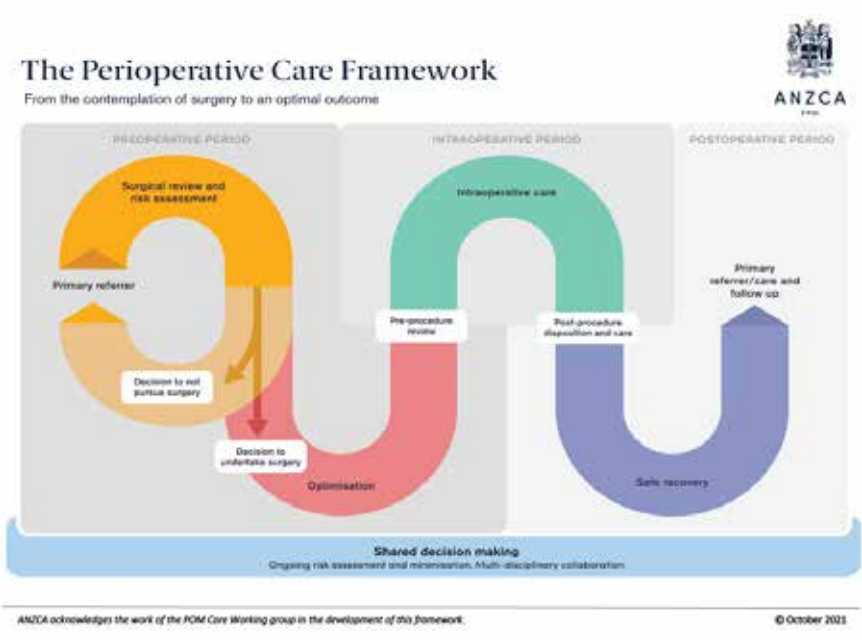


Fig. 1. Visual representation of the perioperative journey.

complications that impact short- and long-term morbidity, mortality, and postoperative quality of life.

The burden of postoperative complications is well-documented, with significant costs and impacts on patients, the healthcare system and society. These costs are often underestimated, as many complications are managed outside the hospital, and indirect costs such as reduced quality of life and inability to work are not often considered.

What Is the Problem?

The current health system is outdated and ineffective in addressing the issues of an aging population, ever more complex patients, increasing prevalence of frailty, and a seemingly ever-increasing number of procedures. Age is a well-known independent risk factor for perioperative complications, and the age dependency ratio in Australia is expected to continue to rise. There is also a higher prevalence of chronic comorbidities, increased cancer incidence, and a rising trend in obesity, a multi-system disorder known to be a perioperative risk factor. Advancements in less invasive procedures and better techniques mean that older and sicker patients are now offered surgeries they would not have been a decade ago.

Can we Solve It?

ANZCA and the Perioperative Medicine SIG continue to advocate for health system reforms to effectively address perioperative complications. High quality POM aims to reduce preventable complications, avoid unnecessary treatment and actively manage waiting lists. To achieve this, we need a paradigm shift in three dimensions:

1. Proactive Care: Transition from reactive to proactive care, focusing on risk assessment, optimisation of health and wellbeing, risk reduction bundles, and perioperative care pathways matched to individual patient risk to prevent and/or minimise perioperative complications, with a foundation of shared decision-making throughout.
2. Collaborative Approach: Shift from fragmented care to a collaborative, coordinated, holistic team approach.
3. Patient-Centred Care: Move from paternalistic, clinician-centred care where the patient is a mere passenger to patient-centred care where patients are in the driver seat: active, engaged, empowered. The benefits of the latter are now well recognised. A national policy blueprint for self-care in health, published in 2020, emphasises the importance of this new direction in healthcare.[4]

Associate Professor Kerridge, in his recent lecture at EBPOM UK, talked about the history of medicine and its hierarchical systems, where clinicians were viewed as God-like figures. The implication being that it is time to sever ties with this antiquated construct. In modern healthcare, there is no longer a place for individual clinicians being heroes, but for a team of clinicians and healthcare workers to collaborate to provide the best healthcare outcome for the patient. Perioperative medicine, as a new discipline, is uniquely positioned to integrate self-care into healthcare provision as proposed in the blueprint at every step of the perioperative journey. Two major concepts for self-care, namely shared decision making and self-efficacy, are central to the new POM care models. This is reflected in the recently updated definition of Perioperative Medicine: 'POM is the science and practice of working with patients from the moment surgery is contemplated, to optimise their health and wellbeing, minimise the risk of perioperative complications, and facilitate optimal recovery, underpinned by shared decision making'. [3]

Where Are We Going?

With the development of ANZCA's Chapter of Perioperative Medicine, the Perioperative Medicine SIG will continue to advocate for POM. We aim for our annual meeting to remain the premier multidisciplinary, multispecialty POM networking event, fostering rich discussions and innovation in POM. In doing so, we would like the POM SIG to be the home for our POM network of people, which continues to grow.

We look forward to seeing many of you at this year's Perioperative Medicine SIG meeting in collaboration with Summit III and PeriOperative Quality Improvement (POQI) in Melbourne, 22-24 November 2024. It promises to be an inspiring event focused on improving quality, enhancing value, and protecting the future of perioperative care.

Dr Jill DF Van Acker

MBChB (honours), FANZCA, MMed(Periop), GChPOM, DipIBLM, PGCertCU
Specialist Anaesthetist
Co-Chair of Perioperative Medicine Special Interest Group

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THE REGIONAL ANAESTHESIA SPECIAL INTEREST GROUP (RA-SIG)

A story of a revolution in regional anaesthesia; the formation and growth of the RA-SIG

A brief history of regional anaesthesia

The chronological history of regional anaesthesia closely follows the history of general anaesthesia, which was first publicly demonstrated by William Morton in 1846 using ether. Another famous William, William Halsted, was the first to publish in 1885 a description of a discrete brachial plexus block using a cocaine solution for upper limb analgesia.[1] While regional anaesthesia as a specialty continued to evolve over the next century, with advancements such as better local anaesthetic agents and nerve stimulation, it is without doubt that a revolution occurred with the adoption of ultrasound-guided nerve blocks in the early 2000s. Ultrasound in regional anaesthesia provided anaesthetists, for the first time, an ability to visualise our target nerve structures, watch real-time spread of local anaesthesia, and avoid critical structures such as pleura and blood vessels.

Early days of the RA-SIG

It was in 2005 that David M Scott (NSW) proposed the formation of a "Regional Anaesthesia Special Interest Group" (RA-SIG) during the ASA National Scientific Congress in Hobart. The timing was appropriate: there was excitement caused by ultrasonography; there was strong unmet need in our specialty for further education and training in regional anaesthesia; and the concept of SIGs was new but encouraged. Thus, despite some resistance, the RA-SIG was approved by the tripartite parent bodies of the Australian Society of Anaesthetists, New Zealand Society of Anaesthetists, and ANZCA; with administrative support provided by the ASA.

David M Scott was the inaugural chair of the RA-SIG executive, and brought together representatives from each Australian state and New Zealand (see breakout box). Important individuals during those formative years included Neil McLennan (NZ), Chris Nixon (NZ), Kerry Gunn (NZ), Michael Barrington (Vic), Peter Hebbard (Vic), David McLeod (SA), and Chris Mitchell (WA).

Ultrasound in regional anaesthesia provided anaesthetists, for the first time, an ability to visualise our target nerve structures, watch real-time spread of local anaesthesia, and avoid critical structures such as pleura and blood vessels.

Very soon after formation, the RA-SIG organised our premier educational event: the Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA). First held in Melbourne under Michael Barrington as convenor, the biannual ASURA remains a highlight of the RA-SIG's educational activities and has brought in notable keynote speakers from Australasia and overseas leaders of regional anaesthesia. The speaking program has been strongly complemented by Australasian regional anaesthesia tutors providing intensive hands-on teaching to delegates. Apart from small group workshops, ASURA has led the world in one of the first to use novel teaching methods including sim centre-based non-technical skills and critical events simulation, and cadaveric workshops. ASURA has subsequently been held in Sydney, Brisbane, Perth, Noosa, Auckland, Adelaide, and next in March 2025 in Hobart.

RA-SIG and the ANZCA Curriculum

Another seminal moment soon after the formation of the RA-SIG was the ANZCA curriculum rewrite in the mid 2000s. Despite the almost as long history of regional anaesthesia compared to general anaesthesia, it is rare for national anaesthesia training curricula worldwide to have a structured curriculum that teaches nerve blocks. The ANZCA curriculum rewrite was thus an ideal opportunity to establish a strong theoretical and clinical framework that would train future Australasian anaesthetists in safe and effective regional anaesthesia.

Championed by David M Scott and Nav Sidhu (NZ) through multiple committee meetings and curriculum writing workshops, regional anaesthesia became one of the five Clinical Fundamentals that forms the present-day ANZCA anaesthesia training program. Almost unique when compared worldwide, the rewritten ANZCA curriculum continues to describe a training program that sets out minimums of competency, workplace-based assessment criteria, and volumes of practice in peripheral and neuraxial nerve blocks.

While this remains relevant to the majority of ANZCA trainees, those undertaking a 12-month provisional fellowship in regional anaesthesia did not have a common curriculum describing a fellowship training structure and learning objectives for. To meet this gap, Nav Sidhu, Chris Mitchell and Alwin Chuan (NSW) published a 2019 recommended curriculum for departments of anaesthesia that has been endorsed by the RA-SIG.[5]

What cannot be understated is the value of the RA-SIG – as a body representing the interests of a large membership base within the anaesthesia community – when advocating for major policy changes to the ASA, NZSA, and ANZCA.

Current RA-SIG activities

The RA-SIG continues to foster a strong educational commitment to national conferences apart from ASURA. These have included organising speakers for at least one, sometimes two, lecture sessions at every ASA National Scientific Congress, ANZCA Annual Scientific Meeting, and NZ Combined Scientific Congress. To meet the constant demand of delegates for regional anaesthesia workshops at these meetings, the RA-SIG has assisted in organising both volunteer-model small group workshops within the conference, as well as offsite cadaveric workshops that serve as major satellite meetings.

A regular newsletter edited by Andrew Lansdown (NSW) is sent to all RA-SIG members with interesting and varied

articles: a research corner discussing the methodology and outcomes of recently published papers; biographies of members and their often un-recognised work in teaching and training and mentoring future anaesthetists; a "how I do it" section of clinical pearls and workflow advice. This newsletter is sent to all members of the RA-SIG, which currently has 413 active anaesthetists.

The RA-SIG also hosts a Whatsapp account (RA SIG members forum), which was established to allow faster communication between members. Recent discussions have included recipes for spinal anaesthesia for day-case/short-stay joint replacement surgery; strategies to introduce and reinforce Stop Before You Block protocols; teaching regional anaesthesia to our emergency medicine colleagues – what, how, and which blocks to teach.

Most recently, the RA-SIG has resumed participation with the Asia-Oceania Society of Regional Anaesthesia-Pain Medicine (AOSRA-PM) after a gap caused by a lack of representation from Australasia. AOSRA-PM brings together the national regional anaesthesia interest groups and societies from countries such as Thailand, India, Cambodia, Vietnam, Bangladesh, South Korea, Philippines, Japan, Singapore, Malaysia, Iran, Mongolia, Hong Kong, Nepal, and Indonesia. Together, AOSRA-PM runs monthly online webinars hosted by each country on topics of interest; Australia will be presenting on 21 November 2025 with talks by Dr Adrian Chin (Qld) and Dr Lisa Webb (Qld).

Finally, AOSRA-PM in collaboration with the European, American, Latin American, and African societies of regional anaesthesia hosted the first World Day of Regional Anaesthesia on January 27 2024. This exciting initiative brought together all the major societies to run simultaneous worldwide online and face-to-face mixed lectures and workshops. The next event will again be held in January 2025 and Australasia will contribute with educational events held during that week.

Conclusion

The RA-SIG has a strong track record of proactively supporting and advocating for regional anaesthesia in Australasia. From its formation, members of the RA-SIG have contributed immensely to the training, education, curriculum design, and ongoing innovation in the subspecialty. We invite anaesthetists with interest in regional anaesthesia to reach out and join the RA-SIG and the Whatsapp chat group (contact an executive member – Box 2); contribute to the newsletter (Andrew Lansdown – NSW); participate in AOSRA-PM events (Alwin Chuan – NSW); and join us in our upcoming meetings (Box 3). We are a vibrant community of keen enthusiasts dedicated to excellence in regional anaesthesia.

Assoc Prof Alwin Chuan

Member of Regional Anaesthesia Special Interest Group

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Former and Current chairs of the RA-SIG

- **A/Prof David M Scott (NSW) – Inaugural Chair**
- **A/Prof Michael Barrington (VIC)**
- **Dr Neil McLennan (NZ)**
- **Dr David McLeod (SA)**
- **Dr Katrina Webster (TAS)**

Current RA-SIG executive

- **Dr Katrina Webster (TAS) – Chair**
- **Dr Andrew Lansdown (NSW)**
- **A/Prof Alwin Chuan (NSW) – Inaugural member**
- **Dr Nav Sidhu (NZ)**
- **Dr Liz Maxwell (NZ)**
- **Dr Kelly Bryne (NZ)**
- **A/Prof Peter Hebbard (VIC) – Inaugural member**
- **Dr Reginald Edward (VIC)**
- **Dr Ross Peake (ACT)**
- **Dr Brigid Brown (SA)**
- **Dr Craig Daniel (QLD)**
- **Dr Chris Mitchell (WA) – Inaugural member**
- **Dr Yean Chin Lim (Singapore)**

Upcoming RA-SIG events

- **21 November 2024 – AOSRA-PM monthly zoom webinar (Australia)**
- **Week of January 20 2025 – 2nd World Day of Regional Anaesthesia**
- **13-15 March 2025 – ASURA Hobart**

RURAL SPECIAL INTEREST GROUP

THE CLOCK TICKS PAST MIDNIGHT, YOU'VE JUST INDUCED THE YOUNG BOY FOR A TRAUMA LAPAROTOMY. THE CLAMOUR OF HIS ARRIVAL IN THE USUALLY QUIET RURAL EMERGENCY DEPARTMENT MADE IT SOON CLEAR HE WOULD NEED URGENT RESUSCITATION AND LIKELY SURGERY. YOUR HEART SANK AS THE RETRIEVAL CO-ORDINATOR TOLD YOU THAT STORMS ON THE COAST WOULD MAKE AN URGENT HELICOPTER EVACUATION IMPOSSIBLE. PERHAPS A ROAD CREW COULD BE THERE BY TOMORROW MORNING. THE SURGERY CONTINUES AS YOU REALISE YOU'VE ALREADY USED TWO OF THE ONLY FOUR UNITS OF BLOOD IN THE HOSPITAL, AND THAT AFTER THE SURGERY THE RECOVERY ROOM WILL BECOME YOUR AD-HOC INTENSIVE CARE UNIT UNTIL HELP ARRIVES. YOUR MIND TURNS TO THE LABOURING PATIENT AND HER EPIDURAL ON THE MATERNITY WARD (HOPEFULLY SHE DOESN'T NEED THEATRE ANY TIME SOON) AND THE FACT YOUR LOCUM ANAESTHETIST HAS PULLED OUT OF COVERING NEXT WEEK, SO GETTING TO THE CONFERENCE IN SYDNEY IS LOOKING LESS CERTAIN…

In the early nineties, these were the sort of conundrums that drove Rural Special Interest Group pioneers like Frank Moloney and Di Khursandi to gather like-minded rural and regional colleagues and survey their biggest challenges. Access to Continuing Professional Development, finding new colleagues, locum cover for leave and the challenges of living in remote Australia were consistent themes. With help from ANZCA, a constitution and secretariat were established, and the Rural SIG was born.

An underlying principle of the SIG is to recognise the importance rural and regional Australians put on quality healthcare closer to home, both for pragmatic and deeply cultural reasons. This might involve anaesthetic care in contexts ranging from major regional city hospitals, to the most remote and austere of rural clinics. The Rural SIG aims to ensure that this care meets the highest standards possible in every setting.

The Rural SIG became one of the few ANZCA Special Interest Groups to actively involve practitioners outside the college in its activities, with Rural Generalist Anaesthetists being involved as Associate members since its inception. It's a recognition of the way specialists and non-specialists work collaboratively throughout the regions, and a way to avoid 'gatekeeping' experience and solutions to help rural patients. Maintaining standards of generalist anaesthesia followed with links to establish the Joint Consultative Council of Anaesthesia certification, and in recent years, advising on the Diploma of Rural Generalist Anaesthesia with ANZCA. The SIG strives for outcomes for rural patients to be similar whether they receive care from a specialist or non-specialist anaesthetist.

The CPD issue was tackled with an inaugural Rural SIG meeting held in Alice Springs in 1993. Since then, the annual Rural SIG meetings have formed a backbone of the group's activities, rotating through host regional destinations in each state of Australia and New Zealand. The SIG meetings provide a valuable forum to share knowledge, skills and experience relevant to anaesthetists outside metropolitan Australia. Themes cover not only the breadth of topics encountered in rural anaesthesia, but the extended scope required by the rural anaesthetist, in perioperative and pain medicine, along with resuscitation and critical care.

Critical care is a recurring theme of the Rural SIG meetings, framed as "The Accidental Intensivist." It recognises that throughout rural and regional Australia, an enormous amount of critical care service is provided by anaesthetists. This includes

A core competency of anaesthetists outside metro areas is to be able to respond with expert skills and knowledge in all manner of emergencies and crises.

prehospital care, resuscitation, intensive care and retrieval medicine, and as rural anaesthetists the reality is that we may be involved in any of these areas from time to time. A core competency of anaesthetists outside metro areas is to be able to respond with expert skills and knowledge in all manner of emergencies and crises. The Rural SIG shares not only continuing education to tackle the challenges of rural critical care, but is a forum to share experiences so that we can respond to emergencies in the country at the highest standard possible in any setting.

Perhaps one of the most important roles of the SIG has been in professional matters, ensuring the peculiarities of delivering anaesthetic and perioperative care in rural areas are recognised. The Rural SIG has consistently had input to ANZCA in the form of advisory to college and professional documents, as well as training and education relevant to rural and regional practice. SIG members routinely advise rural and regional hospitals on anaesthetic and organisational matters, helping managers see some of the adjustments required to the tertiary hospital playbook. The advisory role of the Rural SIG was at the fore during the pandemic, making representations to ensure that edicts from government and health bodies made sense outside the big cities. It's important that groups like ours continue to advocate that decision-makers consider rural Australians in health policy.

What of the next generation of Rural Anaesthetists? This was a key question the founders of the Rural SIG asked in its genesis. How do we ensure that anaesthetists and trainees understand the issues of work in a rural setting, and are energised by those challenges? The SIG promotes rural exposure at the prevocational level, and keeps working to shore up pathways for rural doctors into specialist anaesthetic training. We're seeing now a generation of specialists keen to return to rural and regional practice at the completion of their training, a testament to the importance of rural work before and during ANZCA training. Another exciting development is Rural Training Networks, that see ANZCA trainees spend the bulk of their training in regional hospitals, with rotations to metropolitan centres for subspecialty exposure, rather than the reverse, which was previously the convention.

So how would our ANZCA Rural SIG report card look according to our founders over three decades ago? I think they'd be proud of the continuous strong network of country anaesthetists and the high standards of care they provide across Australia. They would be cautiously optimistic about the selection and training innovations and eventual flow-on effect this will have on the specialist and generalist anaesthetist workforce. And they would be urging us to keep up the pressure on Australia's health leadership to make decisions that properly consider the different contexts of healthcare across Australia's regions.

The ANZCA Rural SIG continues to foster collaboration and communication amongst practitioners in the rural context, spreading the word on best practice and innovation. Across the country we're a bunch of adaptable, resourceful and independent anaesthetists with plenty of knowledge to share to best help rural Aussies. Want to join in the conversation? Visit the Rural SIG via the ANZCA Special Interest Groups webpage.

Dr Craig Mitchell
Chair of Rural Special Interest Group

Dr Craig Mitchell is a specialist anaesthetist working in Ballarat and the Central Highlands of Victoria. He is Chair of the ANZCA Rural Special Interest Group.

ASSOCIATE PROFESSOR
ALWIN CHUAN
CHAIR, SCIENCE PRIZES AND
RESEARCH COMMITTEE

FROM THE SPARC CHAIR

I invite members to apply for the multiple ASA research grants and prizes that are available in 2024.

The ASA has expanded its Research Priority Program with the creation of four new small grants of up to $3000 each per year, for original research into the current ASA Research Priority areas:

ENVIRONMENT & ANAESTHESIA
INNOVATION & ANAESTHESIA
SAFETY IN ANAESTHESIA

Eligibility:

Trainee members, and members within five years of full membership who have been financial members of the ASA for over 12 months. Applicants are welcome from research teams, but at least one member needs to meet the eligibility requirements.

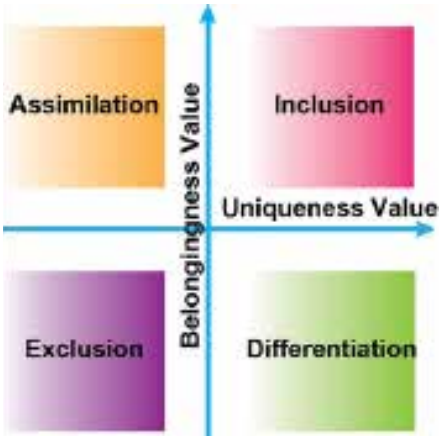
Requirement to present work in a public forum eg a future NSC, publish in a peer review journal, Australian Anaesthetist or ASA podcast.

The research grant may be used to purchase or lease equipment, facilities or material or to fund administrative or scientific support.

FOR FURTHER INFORMATION and APPLICATION FORMS LOG IN TO
asa.org.au/asa-awards-prizes-and-research-grants/
or contact sdonovan@asa.org.au.

2024 CANADIAN ANESTHESIOLOGISTS' SOCIETY ANNUAL MEETING

ATTENDING THE 2024 CANADIAN ANESTHESIOLOGISTS' SOCIETY (CAS) ANNUAL MEETING THROUGH THE ASA TRAINEE SCHOLARSHIP WAS AN EYE-OPENING EXPERIENCE. THE DAYS WERE PACKED WITH INSPIRING TALKS ON THE PLIGHT OF REFUGEE PATIENTS, INFORMATIVE TALKS ON ERAS AND PERIOPERATIVE PAIN MANAGEMENT TRENDS, SUSTAINABILITY IN ANAESTHESIA WORKSHOPS, AND REGIONAL ANAESTHESIA TUTORIALS.



What stood out was the friendly and inclusive atmosphere created by our Canadian colleagues. Between sessions, conversations often revolved around the challenges posed by the workforce shortage in our field. It was surprising to hear stories of anaesthetists managing multiple theatres, having nurses with no anaesthesia training working with them, and hospitals closing theatres due to staff attendance at this very conference. Outside the conference, discussions with local taxi drivers shed light on the broader impact of the healthcare workforce deficit. Stories of long waits in emergency departments (12 hours was considered acceptable) due to a shortage of family doctors in British Columbia were particularly striking.

Speakers like Dr. Gunisha Kuar and Dr. Greg Mannering emphasised the importance of recognising and supporting overseas-trained medical professionals to address these challenges and promote equity, diversity, and inclusion in our healthcare systems. Through a framework pioneered by Shore[1], we gained an appreciation for the difference between differentiation, assimilation, and inclusion. In differentiation, the person's characteristics are valued as desirable, but they aren't recognised as one of us. In assimilation, belonging to the workplace is granted if the individual follows the dominant culture norms. In inclusion, both belongingness and uniqueness are recognised and valued - leading to people feeling respected and appreciated. I invite you all to reflect on how these concepts may place out in your hospital. Overall, we have a collective responsibility to create inclusive environments, with the understanding that this will attract and retain a diverse workforce, support colleague well-being, and improve patient care.

Further reflecting on these discussions, I am reminded of the importance of fostering a profession that appreciates each person and supports their professional growth and personal well-being. For me, this includes opportunities for learning and discussion, meaningful connections with peers, and time spent outdoors—all of which I found at the 2024 CAS 2024 Annual Meeting, thanks to the ASA Trainee Scholarship.

Dr Erika Strazdins

[1] Shore, L. M., Randel, A. E., Chung, B. G., Dean, M. A., Holcombe Ehrhart, K., & Singh, G. (2011). Inclusion and Diversity in Work Groups: A Review and Model for Future Research. Journal of Management, 37(4), 1262-1289. https://doi.org/10.1177/0149206310385943

REFLECTIONS ON 12 YEARS IN THE WFSA LEADERSHIP

WFSA Immediate Past President, Assoc Prof Wayne Morriss

IN MARCH, AT THE WORLD CONGRESS OF ANAESTHESIOLOGISTS IN SINGAPORE, I FINISHED MY TERM AS PRESIDENT OF THE WORLD FEDERATION OF SOCIETIES OF ANAESTHESIOLOGISTS (WFSA). IT WAS A TIME OF MIXED EMOTIONS – I HAD DEVOTED A HUGE AMOUNT OF TIME AND ENERGY TO VARIOUS LEADERSHIP ROLES IN WFSA DURING THE PREVIOUS 12 YEARS AND FELT A MIXTURE OF PRIDE, SATISFACTION AND SOME SADNESS AS MY TIME IN THE WFSA LEADERSHIP CAME TO AN END

The last few months have provided an opportunity for me to reflect on my time in our specialty's global federation. WFSA has come a long way in the last decade, and it has been exciting for me to represent our region and to play a leading role in the WFSA's transformation. It is also a good time to celebrate some of the achievements of the last 12 years.

The WFSA and becoming President

The WFSA is an amazing organisation, but its importance is not always understood by individual anaesthetists (anaesthesiologists), especially those working in well-resourced countries. It is a unique, professional membership organisation, currently made up of 141 national (or multinational) member societies and representing anaesthesiologists in 150 countries. The mission of WFSA is to unite and empower anaesthesiologists around the world to improve patient care. It has an official liaison role with the World Health Organization (WHO) and is the voice of our specialty at key events such as the World Health Assembly (WHA).

My journey to the WFSA presidency started way back in 2000 when I moved to Fiji to take up a 2-year job as a Senior Lecturer in Anaesthesia and Physiology at the Fiji School of Medicine. The ASA provided some funding for the position, and I will always be grateful for this support and the help of many colleagues, including Haydn Perndt and Steve Kinnear.

My involvement with WFSA started in 2008, when I was selected as a member of the Education Committee. In 2012, at the World Congress in Buenos Aires, I became Chair of the Education

With Dr Tedros Adhanom Ghebreyesus, WHO Director-General, World Health Assembly in Geneva, Switzerland, May 2023.

Committee and a member of the WFSA Board and Council. In 2016, in Hong Kong, I was elected Director of Programmes, and in 2020, I became President Elect after virtual elections during the height of the pandemic. My term as President started in July 2022.

It felt like a big deal to be elected WFSA President by colleagues from all around the world. I was the 19th President since the WFSA was formed in 1955, and I was following in the footsteps of people like Harold Griffith, John Bonica, Michael Vickers, Angela Enright, and Australia's Kester Brown. I was only the fourth from the southern hemisphere, and the first from New Zealand.

A transformational time

In 2012, when I joined the Board (or Management Group as it was then known), there was only one paid employee in London. Despite some excellent educational work, the organisation was struggling to make an impact with its advocacy work, and engagement with member societies was patchy. In 2013, the Board, under the presidency of David Wilkinson (UK), took the plunge and employed WFSA's first CEO, Julian Gore-Booth. What followed was a time of rapid change, with a restructuring of the organisation, the development of a highly effective secretariat, and strengthening of WFSA's main roles - education, advocacy and working together.

First, the last decade has seen a strengthening of WFSA's educational offerings, which are freely available to colleagues everywhere in the world. These include:

- Fellowships (short subspecialty attachments aimed at developing leaders and teachers);
- Scholarships for younger colleagues to attend major conferences;
- Publications such as Anaesthesia Tutorial of the Week and Update in Anaesthesia;
- Short courses such as SAFE Obstetric Anaesthesia and SAFE Paediatric Anaesthesia.

During my time as Chair of the Education Committee, we doubled the number of fellowships and rolled out a range of short courses, mainly in low-resource countries.

Second, we have made great strides with advocacy, and have highlighted the importance of anaesthesia in global health. We played an important role in publicising the work of the Lancet Commission on Global Surgery and supported WHO work on strengthening anaesthesia and surgical care. WFSA has now made multiple statements at the World Health Assembly and WHO regional meetings on issues important to anaesthesiologists everywhere – such as workforce well-being and adequate resourcing for our specialty.

Third, we now have much more effective engagement with member societies and have developed valuable relationships with other organisations and funders. During my time on the Board, I attended multiple valuable meetings with the leaderships of national societies in all regions of the world – our region, Europe, Africa and the Middle East, Asia, and the Americas - and large organisations such as the American Society, ESAIC, the Latin American Confederation (CLASA). We have worked with Lifebox and other organisations to distribute oximeters around the world and are now helping with the roll-out of a robust, reasonable-cost capnometer.

First, the last decade has seen a strengthening of WFSA's educational offerings, which are freely available to colleagues everywhere in the world.

Busy at the top

The last decade has been very busy for me personally – I've been effectively doing two full-time jobs – and the last two years have been particularly busy. I tried to make my overseas travel as efficient as possible and combined numerous trips, but I was still overseas for over 20 weeks in 2023. During the year, I gave 26 talks (including 12 virtual presentations) in countries as diverse as Brazil, Azerbaijan, India, United States, Indonesia and Tanzania. I always had an overflowing email inbox and New Zealand's time zone made scheduling of frequent Zoom meetings challenging.

As President, I was very aware that I was carrying on the great work of other recent presidents and other volunteers. David Wilkinson (UK) led WFSA during my first four years on the Board, followed by Gonzalo Barreiro (Uruguay, 2016-2018), Jannicke Mellin-Olsen (Norway, 2018-2020), and Adrian Gelb (USA, 2020-2022). And, of course, it's a team effort. There isn't space to list all the Board members during the last 12 years, but I am particularly grateful to Alan Merry (New Zealand, 2012-2020) and the Board members during my term – Davy Cheng (China), Daniela Filipescu (Romania), Adrian Gelb (USA), Emilia Guasch (Spain), Walid Habre (Switzerland), Carolina Haylock-Loor (Honduras), and Mauricio Vasco (Colombia).

The work of WFSA's Board, Council and Committees is supported by a hard-working and productive Secretariat of thirteen, based in the UK and Spain. Kristine Stave (who previously worked for Lifebox) took over from Julian as CEO in 2022 and is doing an amazing job as leader of the Secretariat team.

WCA Welcome Ceremony: With WFSA Distinguished Service Award winners Jannicke Mellin-Olsen (Norway), Gertrude Marun (Papua New Guinea), Hazel Mumphansha (Zambia).

WFSA Board 2022-2024: Davy Cheng (China), Mauricio Vasco (Colombia), Walid Habre (Switzerland), Adrian Gelb (USA), Daniela Filipescu (Romania), Emilia Guasch (Spain), Wayne Morriss (NZ), Carolina Haylock Loor (Honduras)

Some highlights

There have been many highlights during my time with WFSA. While I was Chair of the Education Committee, I got to know many of the fellowship programme teachers around the world, as well as the trainees, many of whom are now in leadership and teaching positions. I was the lead author of WFSA's Position Statement on Anaesthesiology and Universal Health Coverage which was approved by member societies at the World Congress (WCA) in Hong Kong and was the springboard for our advocacy work at WHO. I attended the World Health Assembly in Geneva on three occasions and presented two statements on behalf of the global anaesthesiology community during plenary sessions.

Peter Kempthorne (also from Christchurch) and I were the lead authors of the Global Anaesthesia Workforce Survey which, for the first time, documented our global workforce and highlighted massive discrepancies between regions. This publication was essential for our advocacy work with governments and WHO. I also co-authored a revision of the WHO-WFSA International Standards for a Safe Practice of Anesthesia, along with Adrian Gelb and Alan Merry. This document has also played a very important role in our advocacy efforts.

It has been satisfying to see some of the benefits of our structural changes, including improved governance and increased member society engagement. WFSA weathered the COVID storm in 2020-2023, and successfully "pivoted" from a planned in-person WCA in Prague in 2020 to a fully virtual congress in 2021. During my presidency, we developed WFSA's strategic priorities for 2023-2028, and worked on a more flexible, modern constitution. This work is not always very exciting but is vital for the effective functioning of a membership organisation like WFSA.

The final highlight for me was a successful WCA in Singapore in March. I was the Co-Chair of the Congress Organising Committee (along with Prof Chan Yew Weng from Singapore) and, not surprisingly, it was a lot of work. We faced a range of challenges before the WCA, but, in the end, we had a very successful congress with over 5,000 in-person attendees from 142 countries, and 525 faculty from 73 countries. The Singapore WCA was also our first opportunity to hold a face-to-face General Assembly since Hong Kong in 2016. I chaired the meeting, and it was very satisfying when member societies approved a range of important constitutional changes.

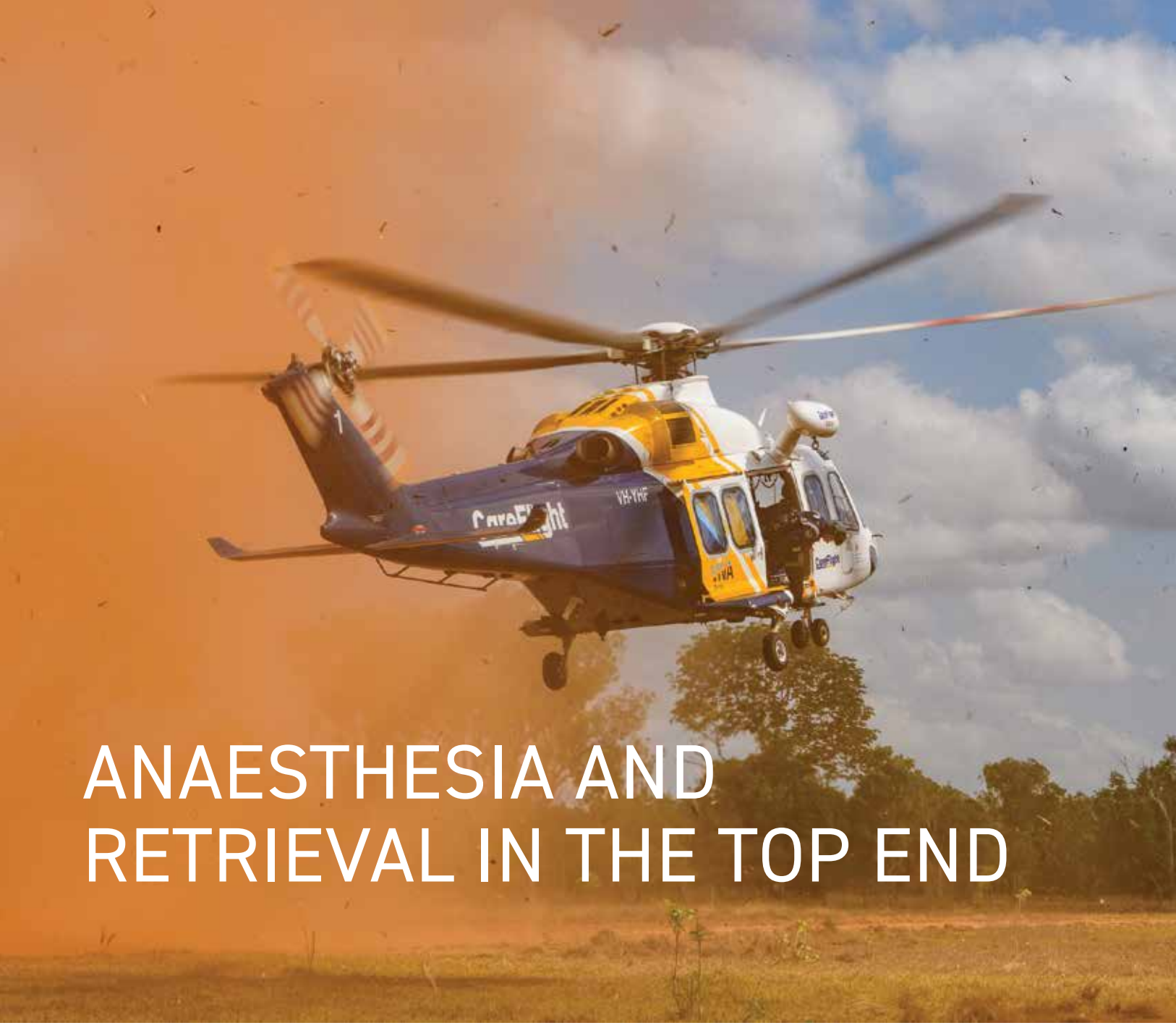
Life post-WFSA

At the closing ceremony of the WCA, I was delighted to hand over the presidency to my colleague and good friend, Daniela Filipescu (Romania). I know that Daniela, the new Board, the Council and Committees, other volunteers and Secretariat will continue to do a great job working on behalf of colleagues all around the globe. It's a good feeling.

I'm still working full-time at Christchurch Hospital but will likely be involved in some project work from time to time, such as SAFE and the Essential Pain Management (EPM) programme. As Immediate Past President, I've got several speaking engagements lined up, including lectures at conferences in South Africa and South Korea, and a number of writing assignments. And, of course, I hope to see many of you at the next WCA in Marrakech, Morocco in 2026.

WFSA brings our global specialty together, and it has been an honour to be WFSA President. Many thanks to family, friends and colleagues for supporting me in this work.

Assoc Prof Wayne Morriss
WFSA Immediate Past President



ANAESTHESIA AND RETRIEVAL IN THE TOP END

Dr James Hooper is a Darwin-based specialist anaesthetist with key professional interests in pre-hospital and retrieval medicine, and trauma anaesthesia. He is the Medical Director of CareFlight NT, a Medical Retrieval Consultant, a Specialist Anaesthetist at Royal Darwin and Palmerston Hospitals, a Medical Officer in the Royal Darwin Hospital Hyperbaric Unit and provides some private anaesthesia, predominantly in orthopaedics. In his spare time, he enjoys getting out and about in the Top End with his ED doctor-wife and daughter, and travelling further afield when the opportunity arises.

WELCOME TO DARWIN AND THE TOP END! THE ASA IS FORTUNATE TO BE HOLDING ITS NSC IN DARWIN THIS YEAR, NESTLED IN ONE OF THE MOST BEAUTIFUL AND CULTURALLY SIGNIFICANT PARTS OF AUSTRALIA AND INDEED THE WORLD. LIKE MANY COLLEAGUES IN DARWIN, I CAME TO THE NORTHERN TERRITORY (NT) FOR 'JUST A YEAR'. HAVING COMPLETED PART OF MY TRAINING IN ANAESTHESIA IN LONDON, UK, I WAS LOOKING FOR ADVENTURE – AND AUSTRALIA BECKONED. FOLLOWING A SHORT STINT IN MELBOURNE AS AN ANAESTHETIC REGISTRAR, I ARRIVED IN DARWIN IN EARLY 2017 DURING PEAK WET SEASON TO TAKE UP A RETRIEVAL REGISTRAR POSITION WITH CAREFLIGHT NT.

Stepping off the aircraft for the first time at Darwin Airport one Sunday night I was immediately hit with a blast of hot, humid air and left the terminal in the midst of a tropical downpour and intense thunderstorm which is so typical of the wet season. Many aspects of life are unique and different in the NT, and I spent my first few days in Darwin questioning my life choices before all my concerns melted away in the NT heat.

Darwin is a melting pot of different cultures, which come together to form the perfect blend. Some of the best of Darwin's cuisine can be found at regular events such as Mindil Beach Market, whilst Darwin also has a thriving art scene. It's difficult to visit Darwin without eating laksa, which one could argue is Darwin's most favoured dish. The weather is usually either warm, dry and ideal for exploring outdoors, or warm, wet, humid and featuring massive thunderstorms. Both the wet and dry seasons are beautiful in their own way.

The Top End is beautiful, rugged, and frequently very remote with large distances between towns and settlements. Much of the population lives around Darwin with other sizeable populations in key towns such as Katherine and Nhulunbuy (Gove). Other communities across the Top End range in size from a few dozen individuals up to several thousand. Health services in remote communities are delivered predominantly by remote area nurses (RANs), with the support of either GPs in the community (if present), or GPs providing telephone advice and management. Both Katherine and Gove hospitals have a 24/7 emergency department.

I had come to Darwin specifically to work for CareFlight, and the day after arriving in the NT I was immersed in the CareFlight induction programme. The training is robust and rigorous, and over nearly three weeks of induction new recruits are put through their paces in aeromedical simulations, and comprehensively trained and assessed as crew members across all the aircraft in which we operate. All our registrar recruits are put through helicopter underwater escape training and trained in winch insertion, extraction, and accompanied stretcher winching. Despite common pre-training trepidation around these exercises, they're surprisingly enjoyable and satisfying to complete.

CareFlight is a leading not-for-profit national aeromedical organisation established in 1986 with a single helicopter. Since then, the organisation has grown significantly to multiple sites across the country, providing healthcare to huge numbers of patients, and utilising numerous aircraft, of varying types. CareFlight NT operates the Top End Medical Retrieval Service on behalf of the NT Government, interstate jet retrievals, inter-hospital road transfers, and works closely with the militaries of several countries to provide aeromedical support.

In the NT we utilise KingAir B200 twin engine turbo-prop fixed wing aircraft as the 'workhorse' of our fleet, allowing us to reach patients in distant locations in a timely fashion in a reliable and robust aircraft. For certain patients and locations, we utilise our fleet of AW139 and BK117 helicopters, and for interstate and international retrievals rely on our Gulfstream G150 and Beechjet B400 jets.

CareFlight brings together some of the finest senior trainees from predominantly emergency medicine, intensive care and anaesthesia, both at registrar and fellow level. Working in aeromedical retrieval in the Top End hones one's skills and ability to cope with both clinical and non-clinical challenges. We are accredited to provide training to ACEM, CICM, ANZCA, RACGP, and ACCRM trainees, and many of our registrars also undertake the Pre-Hospital and Retrieval Medicine Training Programme (formerly known as DipPHRM). I joined CareFlight as a registrar, completed some of my ANZCA provisional fellowship time at CareFlight, and then became a Medical Retrieval Consultant.

Medical Retrieval Consultants are specialists in the provision of critical care, providing telephone support, advice and management plans to RANs, GPs and other healthcare professionals often a great distance away. The most common reasons for patients to be referred to

CareFlight are trauma, cardiovascular or respiratory issues. Medical Retrieval Consultants are also key to decisions around crew mix and logistics, and often this aspect is far more challenging and complex than the management of the medical issue.

I feel privileged to work in such a high-performing organisation, collegiate environment and with dedicated, outstanding colleagues all at the 'top of their game'. Aeromedical retrieval at CareFlight NT really is an anaesthetist's dream, with the best and most advanced equipment readily available. In addition to the standard treatments that one may expect from a flight crew, we can bring highly advanced medical techniques such as awake fibre-optic intubation to patients in the pre-hospital environment.

Working in the NT in aeromedical retrieval can be challenging, however. The climate is often brutal with relentless sun, humidity and temperatures frequently in the high 30s. Personal care, care of the team and of course hydration are crucial for success. Distances are vast across the Top End, and patients are frequently in very remote and difficult to access locations. Missions routinely take two to six hours to complete and can take up to 12 hours or more in certain circumstances. Good teamwork and communication are critical, especially when working in these challenging environments. Human factors skills are recognised to be incredibly important to safety and success, and therefore feature heavily in the comprehensive induction programme.

Sometimes I will work further afield. CareFlight is the preferred retrieval organisation for interstate retrievals on behalf of the NT Government, and inter-hospital retrievals to other Australian cities are very common. I have been fortunate enough to provide CareFlight aeromedical services in other unusual locations, for example to oil rigs off the coast of Broome. Flying for several hours to land on a small platform in the sea, diagnose and treat an unwell patient, and then fly a further few hours back to land is quite a surreal experience.

Physical communications are frequently challenging across the Top End. Mobile phone signal is patchy at best in the remote areas, and when out of mobile phone coverage we rely on satellite telephone and radios. Many of the visual and audio cues that we as anaesthetists rely on for our routine practice in an operating theatre or hospital environment are masked in the aeromedical environment. For example, troubleshooting an intubated patient with poor ventilation in the cabin of a helicopter whilst wearing a flight suit and helmet in a very noisy environment that vibrates and moves is a little different, and arguably more difficult than the operating theatre environment. For this reason, we tend to rely on assessments and investigation less affected by these challenges, such as ultrasound and other cues.

During my initial rotation with CareFlight NT I was fortunate enough to meet then Director of Anaesthesia at Royal Darwin and Palmerston Hospitals (RDH), Dr Brian Spain, who was providing an education session at CareFlight. Following an interview, I was offered a job at RDH as an anaesthetic registrar, and was able to complete ANZCA training.

Royal Darwin Hospital is a busy hospital with nine operating theatres, featuring every surgical specialty apart from elective cardiac surgery. In the past six years Palmerston Hospital has also opened with an additional four operating theatres to provide elective surgery. Anaesthetic training is robust and comprehensive, with a broad exposure to challenging surgery, combined with very complex pathology across all age ranges. The Anaesthetic Department is collegiate and friendly, and working as a specialist anaesthetist here is both professionally challenging and very rewarding.

A small group of anaesthetists provide medical support for the hyperbaric chamber at RDH. Diving-related injuries are relatively uncommon in the NT, courtesy of the high chance of encountering a crocodile, venomous jellyfish, or other marine creature if one did venture into the sea. Wound management therefore forms a large part of the hyperbaric workload.

Darwin and the Top End is a phenomenal location in which to work as an anaesthetist, with huge professional opportunities. I can't recommend it highly enough and encourage you to give it a try.

Dr James Hooper

Medical Director - CareFlight NT

webAIRS

webAIRS

Dr Ross Scott-Weekly and the ANZTADC case report writing group

INCIDENTS DURING PAEDIATRIC ANAESTHESIA:

AN OVERVIEW OF EVENTS REPORTED TO WEBAIRS

Paediatric patients make up a significant proportion of the population who undergo anaesthesia in Australia and New Zealand every year. Children require special considerations for their anaesthetic and perioperative management, and experience tells us they tend to experience a different pattern of adverse events compared to the adult population. Children also undergo general anaesthesia in remote locations such as radiology suites, which can provide logistical challenges, especially during a crisis.

Two large pan-European prospective trials, the NECTARINE Trial[2] and the APRICOT trial[3] have been published looking into the rates and types of adverse outcomes in children undergoing anaesthesia. The APRICOT Trial, which included children from birth to 15 years of age, demonstrated a rate of 5.2% of "severe-critical" events. The NECTARINE trial investigated neonates and infants up to 60 weeks post-menstrual age and reported a "critical event requiring intervention" rate of 35.2%.

To date, there has been limited scrutiny of paediatric events using the webAIRS database[4]. This opportunity for review has led to the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) and the Society for Paediatric Anaesthesia in New Zealand and Australia (SPANZA) to come together to create a subgroup to investigate and summarise paediatric anaesthetic reports to webAIRS. This group of subspeciality paediatric and paediatric-interested anaesthetists has met and begun to develop initial areas of inquiry to move forward.

A brief review of the current paediatric records in the webAIRS database was undertaken; of the 11,235 events currently recorded on the webAIRS database, 1,244 (11%) of these reports relate to paediatric patients. The baseline population of paediatric patients reported to webAIRS is described. It is sometimes also useful to compare these to the adult population and where this is of value, it has been done.

Basic demographic is presented in Table 1. One of the striking findings about paediatric incidents is that they predominantly happen to otherwise well children. ASA 1 & 2 children make up 74% of incidents reported compared to 50% for ASA 1 & 2 adults. There was a preponderance of males at almost 60% of reports. This finding is not repeated in the adult webAIRS reports, which show a slight preponderance towards females.

In terms of surgical specialties for cases, these are recorded in Table 2. Incidents in specialties more commonly undertaken in children such as in ENT and paediatric/general surgery tend to be predominate. Interestingly, despite the degree of comorbidity seen in adult orthopaedic patients, the numbers of reports of incidents are quite similar in both groups. One anxiety provoking anaesthetic is the retinopathy of prematurity laser for ex-premature infants, which can often be quite challenging. It is reassuring to note that only three case reports related to ophthalmology were presented.

Table 1 Basic demographic data of paediatric incidents reported to webAIRS.

	n (%)
ASA	
1	512 (47%)
2	295 (27%)
3	191 (17%)
4	50 (4.6%)
5	10 (0.9%)
Not recorded	21 (1.95%)
Age	
<28 days	46 (4.3%)
29 days – 3 mo	40 (3.7%)
3 mo – 1 yr	112 (10%)
1 yr – 4 yr	366 (34%)
5 yr – 9 yr	239 (22%)
10 yr – 16 yr	276 (26%)
Sex	
Female	367 (34%)
Male	721 (58%)
Not recorded	91 (8.4%)

Table 2 Rates of specialties involved in webAIRS reports, for both paediatric and adult data sets

Specialty	Child n (%)	Adult n (%)
Cardiac	24 (2.2%)	217 (2.5%)
Endoscopy	14 (1.3%)	561 (6.2%)
ENT	212 (20%)	437 (4.8%)
General	174 (16%)	1906 (21%)
Maxillo Facial	41 (3.8%)	161 (1.8%)
Neurosurgery	35 (3.2%)	317 (3.5%)
Obstetrics & Gynaecology	14 (1.3%)	1225 (13.5%)
Opthalmology	3 (0.3%)	8 (0.1%)
Orthopaedic	150 (14%)	1609 (18%)
Other	137 (13%)	485 (5.3%)
Plastics	61 (6%)	293 (3.2%)
Procedure not involved	26 (2.4%)	81 (0.9%)
Radiological	72 (6.7%)	125 (1.4%)
Thoracic	19 (1.8%)	78 (0.9%)
Urology	28 (2.6%)	547 (6.0%)
Vascular	3 (0.3%)	436 (4.8%)
Not recorded	66 (6.1%)	588 (6.4%)

One anxiety provoking anaesthetic is the retinopathy of prematurity laser for ex-premature infants, which can often be quite challenging. It is reassuring to note that only three case reports related to ophthalmology were presented.

Reported outcomes for paediatric incidents reported to webAIRS are shown in Table 3. Almost 50% had no effects, and 22% had a minor effect. Death was an extremely rare incident, occurring in just 0.9% of reported cases. The webAIRS system asks if an incident was preventable and just two of the deaths in the webAIRS database were considered preventable across the reports.

Table 3 Outcomes for paediatric incidents reported to webAIRS

Outcome	n (%)
No effects	493 (46%)
Patient dissatisfaction	9 (0.9%)
Case Cancelled	37 (3.4%)
Minor Effects	240 (22%)
Prolonged length of Stay	91 (8.4%)
Unplanned ICU/HDU Admission	137 (13%)
Death	10 (0.9%)
Not recorded	62 (5.75%)

As would be expected this baseline data is consistent with anaesthetic incidents in children being different to those in adults. This baseline data hints at the valuable insights that may be gleaned from detailed analysis of the reports which is well underway.

Information collected by webAIRS is not just the statistical data presented above. Using the free text information, it also allows for thematic analyses. The major paediatric paper published by the webAIRS group at this stage[4] assessed incidents relating to paediatric regional anaesthesia. Themes extracted from this research included "local anaesthetic dosing, cognitive overload, inadequate preparation and communication breakdown". The comprehensiveness of the information collected allows for some quite sophisticated analysis, with the end game being to maintain the safety of anaesthesia for children.

The success of webAIRS and the benefits of our publications rely on the generous reporting provided by our anaesthesia community in Australia and New Zealand. Please take the time to ensure your organisation is registered with webAIRS. Your incident reports are a valuable contribution to promoting safer anaesthesia for our paediatric and adult patients.

References

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BERNARD RUPASINGHE

POLICY AND PUBLIC AFFAIRS MANAGER

POLICY UPDATE

ASA Workforce Modelling Report

"Anaesthetist workforce under-supply is significant and will worsen".

Background

In 2023 the ASA commissioned a report by HealthConsult to explore the current state of the anaesthetist workforce in Australia and develop a workforce planning model up to 2032.

The workforce modelling report was launched at Parliament House, Canberra on 14th August 2024. This article provides a brief overview of the key findings of the report. A copy of the full report can be downloaded from the ASA website.

The bottom line is that there are predicted shortfalls in the supply of anaesthetists relative to future demand. Unless measures are taken, Australia's anaesthetist workforce under-supply is significant and will worsen.

Key findings

- Demand for anaesthetic services is expected to **increase by 35.7% between 2017 and 2032.**
- The **anaesthetist workforce in Australia is predicted to increase only 31.8% in this time,** from 4,594 to 6,055 anaesthetists.
- In 2027 there is estimated to be a **4 per cent shortfall gap between the forecast and required workforce.**
- By 2032, the forecast workforce shortfall is **expected to reach a 5.7 per cent.**
- **One fifth of anaesthetists are expected to retire** within five years (National Health Workforce Dataset (NHWDS)).
- Anaesthetists' working hours are unlikely to match workload into the future.

To meet the challenge identified in the report, it proposes two options.

Increase the Productivity of Anaesthetists

To meet the projected level of demand for anaesthetic services, anaesthetists would need to increase workload by 2 per cent in five years, or 5 per cent in ten years.

Both the ASA member survey and the National Health Workforce Dataset (NHWDS) suggest an increase in workload is not likely. On average anaesthetists intend to reduce their work by 1.11 hours per week (a 2.6 per cent reduction in workload).

Addressing public hospital funding shortfalls and employment conditions would help improve anaesthetic output.

Improving patient flow, public hospital efficiencies, as well as incentivisation for staff to do additional work, could have a significant impact on public hospital productivity.

Additional Trainees Progressing to Fellows

The ASA has examined the impact of the Australian and New Zealand College of Anaesthetists' (ANZCA) additional trainee data. While the increase in the number of 2024 trainee positions is encouraging, it does not materially alter the shortfall.

Simply, it is the number of additional, admitted fellows as specialist anaesthetists that needs to increase year on year to mitigate the depth and duration of undersupply.

The annual number of graduating fellows entering the workforce must be increased.

56 new fellows annually would need to obtain fellowship every year from 2024 to 2027, or 39 from 2024 to 2032, to bridge the anticipated undersupply.

The pipeline of specialist anaesthetists could be improved by increasing the number of training places funded by state and territory governments based on analysis provided by the Department, assuming no change in workforce participation to that already indicated (2.5% decrease).

If this approach was adopted, the undersupply would start to be mitigated by 2027 and move closer to balance by 2032.

A Combination of the Above

A third option would involve anaesthetists increasing their workload (productivity) as well as increasing trainee numbers to boost the number of graduating fellows entering the workforce each year.

Commentary by the ASA

First and foremost, the ASA supports maintaining the current medical model of anaesthetic care to ensure that the safety and quality of outcomes is not compromised by alternative models of care.

Second, with all available data indicating anaesthetists are not likely or willing to increase hours worked in future, the most plausible option is to increase the number of trainee anaesthetists (and therefore fellows admitted as specialist anaesthetists) to meet future levels of demand for services. However, this will require state and territory governments to adequately fund new trainee positions (and not cut or reduce current trainee numbers) in their respective public health services.

Adopting this approach, in addition to maintaining current processes for credentialling specialist international medical graduates (SIMG) and increasing the number of domestically qualified general practice (GP) anaesthetists, is the ASA's preferred approach to solving the predicted workforce shortage without compromising standards.

Finally, the ASA cautions against any reliance on short-term measures that may compromise standards, and therefore, safety and quality which is the hallmark of care provided by anaesthetists in Australia and an expectation of the Australian community.

As this report clearly demonstrates, there are predicted shortfalls in the supply of anaesthetists relative to future demand. Unless measures are taken soon, Australia's anaesthetist workforce under-supply is significant and will worsen out to 2032.

Training new anaesthetists is neither a cheap nor quick process. Nevertheless, the number of new trainees needed between now and 2032 to meet future demand is extremely modest in comparison to workforce shortages in other areas.

For example, A recent Nursing Supply and Demand Study published by the Department shows that while both supply and demand of the nursing workforce is estimated to increase during the projection period (2023-35), supply is not expected to keep pace with demand. Baseline projections across all sectors (acute care, primary health and aged care) show an undersupply of 70,707 FTE nurses by 2035 with around 79,473 nurses needed to fill the gap. In 2021, the Committee for Economic Development of Australia (CEDA) found that Australia was facing a shortage of at least 110,000 direct aged-care workers within the next decade unless urgent action was taken to boost this workforce.

Increasing the number of new anaesthetists entering the workforce by between 39 and 56 new graduating fellows each year seems relatively simple and cost effective by comparison.

About the study

This study was commissioned by the ASA to ascertain the extent of the issue, and identify possible solutions without compromising safety and quality, or overcorrecting in the short, medium, and longer term.

It examines different scenarios on demand and workforce participation, which both impact the extent and duration of the predicted workforce shortage.

The ASA methodology was presented to the Australian Government Department of Health and Aged Care (DoHAC) Health Workforce Data Intelligence Unit to ensure approaches to modelling were similar and to minimise variation in interpretations. The ASA also consulted with ANZCA to ensure that the data it had sourced was accurate. The ASA found that the data from the Department, ANZCA and NHWDS was closely aligned.

A copy of the full report can be downloaded from the ASA website.

New MBS item - continuous nerve blockade using a catheter technique

IN NOVEMBER 2022 THE ASA MADE AN APPLICATION TO THE MEDICAL SERVICES ADVISORY COMMITTEE (MSAC) FOR A NEW MBS ITEM FOR CONTINUOUS NERVE BLOCKADE (CNB) USING A CATHETER TECHNIQUE. THIS WAS THE RESULT OF SEVERAL MONTHS' WORK BY THE ASA'S ECONOMICS ADVISORY COMMITTEE AS WELL AS REGIONAL ANAESTHESIA SPECIAL INTEREST GROUP MEMBERS.

In the Application Summary, which can be downloaded from the MSAC website, the service is described as follows:

Major peripheral nerve block, performed perioperatively, with the introduction of a catheter to allow continuous nerve blockade, to provide postoperative pain relief where pain duration exceeds the duration of a single injection. The technique is very similar to performing a major nerve block, however with the addition of the placement of a catheter in close proximity to the relevant nerves (often within the sheath).

Just before this article went to print, the ASA was informed by the Department of Health and Aged Care that a new MBS item for continuous nerve blockade using a catheter technique will be introduced on 1 March 2025.

About the Medical Services Advisory Committee

The MSAC is an independent non-statutory committee established by the Australian Government Minister for Health in 1998.

The MSAC appraises new medical services proposed for public funding and provides advice to Government on whether a new medical service should be publicly funded (and if so, its circumstances) on an assessment of its comparative safety, clinical effectiveness, cost-effectiveness, and total cost, using the best available evidence.

The MSAC's supported MBS item descriptor

Category 3 – THERAPEUTIC PROCEDURES Group T10 – Relative Value Guide For Anaesthesia – Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 19 – Therapeutic And Diagnostic Services
MBS item xxxx Perioperative introduction of a plexus or nerve block to a peripheral nerve, using an in situ catheter in association with anaesthesia and surgery, for post operative pain management (4 basic units). (See para TN.10.17 of explanatory notes to this Category)
Fee: $87.20 Benefit: 75% = $65.40

Note: 75% benefit is payable for treatment of hospital inpatients. $87.20 represents 4 units as at 1 November 2023.

Amendments and reviews of existing services funded on the MBS or other programmes (for example, blood products and blood-related products; or screening programmes) are also considered by the MSAC.

The MSAC's advice to the Health Minister

In April this year, after considering the strength of the available evidence in relation to comparative safety, clinical effectiveness, cost-effectiveness, and total cost, the MSAC supported the creation of a new MBS item for CNB for the management of moderate to severe post-operative pain.

The MSAC considered that despite the limited and uncertain evidence there was probably a small but important benefit compared to single nerve block (SNB) or systemic opioids. There may potentially be other downstream benefits, including reducing opioid use.

The MSAC also said utilisation should be monitored two years post implementation.

Unfortunately, the MSAC considered that no evidence was presented regarding non-operative use of CNB (i.e. for injury or trauma), and therefore it could not advise on extending the supported service to include this indication.

Furthermore, despite the ASA proposing an MBS fee of $104.75 (equivalent to five basic units), the MSAC considered the appropriate fee should be set at four basic units based on other relative value guide services with comparable complexity.

New MBS item

Up until this point, the Department would usually provide advice to the Health Minister on the MSAC's deliberation and seek authority to put forward the new policy proposals (i.e. a new MBS item) either through the Budget or Mid-Year Economic Fiscal Outlook process which can take twelve to eighteen months. The Government usually follows the advice of the MSAC and the Department.

However, under new delegation powers granted to the Minister for Health and Aged Care (for annual expenditure under $20 million), a new MBS item for continuous nerve blockade using a catheter technique has now been approved by the Minister. The new item will be introduced on 1 March 2025, significantly reducing the time usually taken to implement similar items numbers in the past.

The ASA would like to thank the Chair of the Economics Advisory Committee, Dr Michael Lumsden-Steel, as well as Dr Andrew Mulcahy, Associate Professor David M. Scott and Associate Professor Alwin Chuan for the work they put in to make this application to the MSAC.

The MSAC considered that despite the limited and uncertain evidence there was probably a small but important benefit compared to single nerve block (SNB) or systemic opioids.

For more information about the ASA's application to the MSAC for a new MBS item for continuous nerve blockade using a catheter technique visit www.msac.gov.au/internet/msac/publishing.nsf/Content/1741-public

For more information about the MSAC generally, visit www.msac.gov.au.

Bernard Rupasinghe

Policy and Public Affairs Manager

DR MICHAEL
LUMSDEN-STEEL
EAC CHAIR

ECONOMIC ADVISORY COMMITTEE

Regional Anaesthesia Update

Increasingly, regional anaesthesia is being incorporated with initiation of anaesthesia for post-operative pain management, and/or as the primary anaesthesia technique. Enhanced recovery after surgery and hospitals pathways are exploring options that facilitate early mobilisation, early discharge, as well as reducing opioid requirements, and all the side effects from opioids.

Anaesthetists are also increasingly performing regional anaesthesia blocks, single shot +/- insertion of catheter, for pain management, as a procedure, and not in association with anaesthesia.

MBS Items for regional anaesthesia procedures: Regional techniques performed in association with Initiation of Anaesthesia

It is very important that anaesthetists are aware of the correct claiming of MBS items, and that there is a clear distinction between being the anaesthetist (Initiation of anaesthesia) versus performing a procedure for pain management. The MBS items for patient rebates for all therapeutic and diagnostic procedures performed in association with anaesthesia are within the MBS Anaesthesia Relative Value Guide section of the MBS (specifically Category 3, Group T10, Subgroup 19 Therapeutic and Diagnostic Services).

The MBS makes no distinction with respect to the type of anaesthesia provided. Where the regional techniques is the initiation of anaesthesia for the procedure, with no other form of anaesthesia, the initiation of anaesthesia is the regional block, and there is no separate MBS item for the regional service provided.

For selected regional blocks that provide postoperative pain relief additional MBS items within Subgroup 19 may apply. MBS item 22041 applies where the regional plexus or nerve block is an adjunct to anaesthesia (single shot +/- *regional catheter insertion), and is proximal to the elbow and the knee, and is for post-operative management, MBS Item 22041 is applicable

> *22041 Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post-operative pain management. (2 units)*

The regional anaesthesia techniques in association with anaesthesia are currently limited to 4 MBS items: specifically 22041, neuroaxial techniques 22031/22036, and the eye block 22042. Anaesthetists should note that the **MBS does not permit** the claiming of the eye block 22042 number where a General anaesthetic is also a component of anaesthesia.

It is very important that anaesthetists are aware of the correct claiming of MBS items, and that there is a clear distinction between being the anaesthetist (Initiation of anaesthesia) versus performing a procedure for pain management.

The ASA has discussed with the Department of Health (DoH) a range of appropriate regional techniques for post-operative analgesia, including the relatively new, and evolving trunk blocks. The Department has confirmed that 22041 does cover the recognised trunk blocks for pain management – such as transverse abdominal plane (TAP) block, rectus sheath technique, erector spinae plane block, serratus anterior block, and "Pec" blocks. Note that the ASA has

The ASA has discussed with the Department of Health (DoH) a range of appropriate regional techniques for post-operative analgesia, including the relatively new, and evolving trunk blocks.

recommended that for TAP Blocks, a 22041 should only be claimed only once (even where there 2 sites of injection, as an effective bilateral tap block is targeted plane injection, reflecting the relative value and complexity of the TAP block). Likewise where post operative analgesia for the chest wall is provided by Pec 1 and Pec 2 block regional techniques, 22041 should only be claimed once (undertaken at the same site, with minimal redirection of the needle- not a 22041 for a "Pec 1" plus a 22041 for Pec 2). An axillary brachial plexus block, is a single plexus block (despite targeting injection of local anaesthetic at the musculocutaneous nerve, radial nerve, ulnar nerve, and median nerve) is covered by a 22041 claimed only once.

* New MBS item: nerve catheter insertion for post-operative analgesia is expected to be finalised and included in the MBS from 01 March 2025.

ASA Items for regional anaesthesia procedures: Regional techniques performed in association with Initiation of Anaesthesia

The ASA has ASA RVG items for regional anaesthesia techniques for post-operative analgesia, and members should be aware of the ASA RVG item numbers, and the higher unit value for CV081- major nerve block (proximal to the elbow or knee, including intercostal block(s) or plexus blocks to provide post-operative pain relief (4 units) versus CV082 minor nerve block to provide post-operative pain relief (this does not include subcutaneous infiltration) (2 units). Where a TAP block is performed, CV081 should be claimed only once, not twice.

ASA Item for Regional Anaesthesia Catheter procedure

Whilst there is currently no MBS item for a regional catheter technique- these are all currently included in 22041 (22031 for neuraxial epidural), ASA item CV083 (5 units) is specifically for the

> *Major Peripheral Nerve Block, performed perioperatively, with the introduction of a catheter to allow continuous nerve blockade, to provide post-operative pain relief.*

Patients only receive a rebate for MBS items from the Anaesthesia RVG section – Category 3, Group T.10, subgroup 19 Therapeutic and diagnostic procedures in association with anaesthesia. Medicare and Private health insurers do not rebate ASA items (exception being the top AMA level cover in the Doctors Health Fund which rebates AMA items)

Use of Ultrasound (US): Regional techniques performed in association with Initiation of Anaesthesia

There is no MBS item for US use by anaesthetists for any procedures in association with anaesthesia (excluding intraoperative TOE). The ASA has previously submitted a MSAC application for the use of US, which was rejected. At recent discussions with the DoH, the DoH position is that ultrasound use is becoming the expected standard of care, specialists have been appropriately trained in its use, and the devices are largely provided by the facility. The ASA has noted that there are anaesthetists who have purchased, and maintain their own US devices. The relevant MBS note is IN.0.14;

> *IN.0.14 Restriction anaesthetic items in conjunction with item 55054*
>
> *Medicare benefits will continue to be available for the procedures alone and whether individual anaesthetists choose to use ultrasound to assist with those procedures is a matter of clinical judgement for those providers.*

The ASA items for the use of US in association with vascular access and nerve blocks are

> CV800 the use of two-dimensional Ultrasound guidance to assist percutaneous major vascular access (including arterial access and the insertion of peripherally inserted central catheter) (Note this item may be used in addition to the relevant item for vascular catheterisation) (3 units)

and

> CV805 the use of two-dimensional Ultrasound guidance to assist percutaneous major neural blockade. (Note this item maybe used in addition to the relevant nerve blockade item) (3 units)

The ASA recommendations were updated in the 2024 ASA RVG book that: a maximum of one US claim be made per episode of care i.e. one of CV800 or CV805 (regardless of the number of procedures) where the US device is provided by the facility. Where the anaesthetist provides and maintains the US device, that anaesthetists can claim CV800 and CV805 per item.

MBS Item: Ultrasound Use for targeted Percutaneous nerve block, as a pain procedure.

55054: Ultrasonic cross-sectional echography, in conjunction with a surgical procedure (other than a procedure to which item 55848 or 55850 applies) using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R). An item in Group T10 (Relative Value Guide) cannot be claimed in association with item 55054 (ultrasound when used in conjunction with procedures). The US device must also be registered with Medicare for billing.

Assistance at anaesthesia- performing a regional block:

Where there is an anaesthetist who is providing assistance at anaesthesia, and that "assistant anaesthetist" performs a regional technique, or any other procedure, those services are covered by an item within the MBS Anaesthesia RVG section, specifically Category 3, Group T.10, subgroup 19. The nerve blocks identified in Category 3, Group T7 cannot be claimed by an assistant at anaesthetist.

Where a second anaesthetist is in attendance to perform a procedure and is not involved in providing the anaesthetic: (i.e. NOT claiming anaesthesia assistant items): e.g. performs the vascular access, nerve block, they are able to claim for any block that is covered in Group T7 (nerve blocks). Nerve blocks for pain relief are outlined below.

MBS Items: Regional anaesthetic nerve blocks performed for management of pain, not in association with anaesthesia

Pain specialists will be very familiar with these items, and pain specialists are eligible for specific MBS pain management consultation items. Regional nerve blocks, performed for pain management, are specified at **MBS Category 3, Group T7 Regional or Field Nerve Blocks** (MBS Items in the range 18xxx).

Where an anaesthetist is performing a specific block for pain management, they must be aware that consultation items 17640-17655 range are 1) for the patient review, assessment, and consent process, 2) must be a separate attendance to performing a block procedure, and 3) attendance items do not include any time that is required to perform the block. The time that the procedure takes is included in the MBS fee for that procedure.

Attendances to adjust +/- bolus a continuous catheter infusion for analgesia is MBS item 18222/18225, otherwise pain management attendances at 17640-17645 etc.

The Table below guides the Group T7 Regional or Field Nerve block MBS Items to be used for common block performed for pain management. As these items are a procedure, they have a fee assigned to them, rather than having a unit value. The MBS fee schedule was updated in the 01 July 2024 MBS update; https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B013E0789A07D708CA258B030013670A/$File/PDF%20Version%20of%20the%20MBS Book%20-%201%20July%202024.pdf

Dr Michael Lumsden-Steel

EAC Chair

Nerve Block Description	MBS item	ASA Item
Paravertebral Block+/- catheter	18276 PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	CV241
Erector Spinae Plane +/- catheter	18276 PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	CV241
Serratus Anterior Plane +/- Catheter	18258 INTERCOSTAL NERVE (single), injection of an anaesthetic agent	Cv220
Brachial Plexus	18254 Brachial plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	Cv215
Rectus Sheath	No MBS item for block. Attendance item only	CV250
TAP Blocks	18262 Ilio-inguinal, ilio-hypogastric or genitofemoral nerves, one or more of, injections of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	CV225
Femoral Nerve	18270, FEMORAL NERVE, injection of an anaesthetic agent	CV238
Saphenous Nerve	18272 SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	CV239

DR PETER WATERHOUSE
PIAC CHAIR

PROFESSIONAL ISSUES ADVISORY COMMITTEE

Political intervention, medical standards and public outcomes: what is compromised?

THE QUALITY OF HEALTHCARE IN AUSTRALIA IS VERY HIGH BY WORLD STANDARDS.[1] POST-GRADUATE SPECIALIST TRAINING IS PROVIDED BY MEDICAL PEERS, ON A PRO-BONO BASIS. GRADUATES OF SPECIALIST TRAINING ENJOY THE TRUST AND CONFIDENCE OF THE PUBLIC.

SURPRISINGLY, OUR EXEMPLARY SYSTEM IS UNDER ATTACK FROM GOVERNMENTS AND THEIR BUREAUCRACIES. WHY SHOULD THIS BE SO, AND HOW CAN THE PROFESSION MAINTAIN ITS HIGH STANDARDS IN THE FACE OF SUCH INTERFERENCE?

Professions are vital to the function of liberal western societies. Our legal and judicial systems underpin individual freedoms and allow businesses to trade with confidence. Similarly, public confidence in accountants, engineers and others is underwritten by the high standards each profession sets for itself. Government involvement is through occupational registration or licensing, justified by the need to protect the public from sub-standard service. [2]

Professions are perhaps best described as private bodies with public functions.[3] They are populated by bright, capable people and membership is associated with privilege and duty. Standards set by the professions usually exceed the minimum requirements for occupational registration by the government.

Professions inevitably attract description as elitist and inscrutable, answering only to themselves. Underlying this characterisation is the basic truth that there is no other suitable source of oversight. Professional status is therefore an implied contract to serve society, in return for the protection and privilege society extends to the professions. [3]

Quality and Independence

The independent medical profession has been good to Australia. Medical school graduates are guided through rigorous specialist training at the hands of their senior colleagues. Patients are protected by our medical apprenticeship model, where responsibility for all treatment by trainees is shared by a mature practitioner. This process is managed by our Colleges, composed exclusively of senior specialist medical practitioners. Doctors from overseas seeking to practice as specialists in Australia are assessed by the colleges for equivalence.

Alleged deficiencies in this process have led to an unprecedented assault on Australian medical colleges, including ours.

Medical Workforce: a Trojan Horse?

Australia has 6042 registered specialists in anaesthesia.[4] This equates to 23 anaesthetists per 100,000 people.

According to the Global Anaesthesia Workforce Survey by the World Federation of Societies of Anaesthesia[5], Australia is one of very few countries with a number greater than 20.

Professional status is therefore an implied contract to serve society, in return for the protection and privilege society extends to the professions.

Yet the Australian government has plans to reduce the standards of specialist assessment in the name of getting more anaesthetists into Australia from overseas.

At the request of national cabinet, former public servant Robyn Kruk led a rapid review of Australia's regulatory settings for the registration of overseas health practitioners and the recognition of their skills and qualifications.[6]

An explicit recommendation of the review was to transition "equivalence assessments from specialist colleges to the Australian Medical Council", a government-controlled body whose stated purpose is to "ensure that the standards of education, training and assessment of the medical profession promote and protect the health of the Australian community."

Despite the world-leading number of anaesthetists in Australia, anaesthesia was identified as a priority by the federal government, along with psychiatry, general practice and obstetrics.

This is all the more surprising given that the assessment process by our college is among the most efficient.

Maldistribution versus shortage

A recent workforce assessment by the ASA pointed to a modest shortfall of anaesthetists relative to the requirements of our health system.[7] It estimated the shortage would be 4% by 2027.

The magnitude of this estimated shortfall hardly justifies the reactionary and injudicious abandonment of the high standards of Australia's medical profession.

However these innocuous statistics overlook the difficulties associated with providing specialist medical services in rural and regional areas. This perennial problem is a constant irritant to governments who are held responsible by the public for patchy medical services in the regions.

Governments are understandably drawn to easy solutions, like importing foreign doctors to work where the locals will not. Unfortunately this strategy has limitations.

Australia is already reliant on internationally qualified doctors, who make a great contribution to our healthcare system. In 2019, 32.9% of Australia's medical specialists were International Medical Graduates (IMG).[8]

Fast-tracking a few more and expecting them to work in challenging areas is unlikely to be successful.

More likely outcomes of disrupting the assessment process will be lowering of standards and increased government control of the medical profession.

This approach has failed before

State departments of health are exposed to intense political pressure. The temptation to avoid due process against their better judgement has led to fatal consequences. The Bundaberg affair involving American surgeon Jayant Patel was a tragedy. Both Dr Patel and the population of Bundaberg suffered as a result of rash and reckless disdain for the systems in place to prevent such failures.[9]

AHPRA and the growing reach of government

In 2010, state medical boards were replaced by the Medical Board of Australia (MBA). The MBA is not an independent body. It is one of 16 regulated bodies under the umbrella of the Australian Health Practitioner Regulation Agency (AHPRA). Other AHPRA professions include osteopaths, Chinese medicine practitioners and chiropractors.

Since 2010, AHPRA has practically overtaken the role of the MBA.

This might sound like a trivial administrative change, but the medical boards kept the government at arm's length. Remember, the purpose of registration or licensing is protection of the public from poor service.

The creation of AHPRA gave governments the opportunity to wield executive power over supposedly independent professions. This in turn exposes the public and profession to short-term political interference, with no guarantee of good outcomes. In practice the profession will be expected to sign off on the government's ideas, good and bad.

Ideas like lowering standards of anaesthesia practice in the country with one of the biggest and best trained anaesthesia workforces for the population it serves.

The profession is not to be blamed for difficulties attracting highly qualified specialists to regional areas. More often than not, there are local factors at play. There are intractable issues of spouse employment, educational opportunities for children, access to collegial support and other personal considerations. But beyond these, there are administrative factors which are amenable to government intervention, if the will exists.

From the state health department perspective, a full time IMG, bound to the employer for a fixed period, represents a simple solution. Perhaps a more durable solution would be to take a broader view, acknowledging that patients access healthcare in the public and private sectors simultaneously. Perhaps appointing Visiting Medical Officers to public hospitals and facilitating private practice would create a truly appealing career path for doctors in

regional centres. Unfortunately such an approach crosses jurisdictions, making it unpalatable to either state or federal departments of health.

It is easier to demonise and emasculate the medical profession.

How should the profession respond?

At the outset it is important to recognise that there is no conflict of interest between patients and the profession. Both seek high quality healthcare, delivered by a well-trained workforce.

It is also important for doctors to remember that despite the political noise, we're doing a pretty good job. The standard of Australian medicine is enviable.

Finally, we should not be complicit in poor governance. If the government is determined to deliberately reduce standards to bring down the Colleges, we won't help patients or the broader profession by going along with them. The point of increasing control over the profession is to make political decisions look like medical ones. We would fail the public if we allowed this to happen. We would no longer deserve the privilege and protection afforded to professions under the unwritten contract with society.

Rather, we should politely point out the risks inherent in the suggested changes, asking if the government really wants to go down this path of lower standards for patients. It is unlikely that the public would consider this a positive move.

Dr Peter Waterhouse

PIAC Chair

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AROUND AUSTRALIA

Western Australia

Dr Archana Shrivathsa

Chair of the Western Australian Committee of Management

ASA Committee Members and advocacy

The WA Committee would like to welcome our new members Dr Reshma Pargass and Dr Trevelyan Edwards, who commenced in May 2024. Dr Edwards will also be representing WA on the ASA Public Practice Advisory Committee. Dr Maya Calvert was confirmed as Deputy Chair of the committee at our AGM in May.

We farewell and thank outgoing member Dr Ian Forsyth for many years of dedicated involvement with the ASA WA committee, in particular developing our local welfare network and providing a first point of contact for anaesthetists requiring support. He is succeeded as Welfare representative by Dr Mike Soares.

The ASA committee have been involved in a number of advocacy issues on behalf of WA members, including:

- negotiations with the Licensing and Accreditation Regulatory Unit (LARU) WA regarding novel accreditation requirements for WA private hospitals and day surgery facilities, and
- developing guidance for WA anaesthetists affected by health insurer differential rebate policies for emergency work.

CPD in Western Australia

We've had several well-attended ACE events recently including:

- Morbidity and Mortality workshop on Monday 27th May, facilitated by Dr Bridget Hogan and Dr Suze Bruins
- CICO Emergency Response workshop on Tuesday 18th June, facilitated by Dr Sam Fitzpatrick and Dr Jingjing Luo.

Other events for 2024 are listed on the ANZCA events page WA ACE Lecture Series 2024 (https://www.anzca.edu.au/events-courses/events/regional-cme-events/ace-anaesthesia-regional-cme-events/wa-ace-meeting-(2)) including an upcoming gastric and lumbar ultrasound workshop, a second Morbidity and Mortality workshop, and the 2024 WA ACE Country Conference at the Pullman Bunker Bay Resort.

Upcoming events

- ASA WA Cocktail Night – Saturday 5th October, venue TBA
- Part 3 Course – Friday 29th November, UWA Club.

Thanks to Dr Merredith Cully for organising both of these exciting events!

Queensland

Dr Graham Mapp

Chair of the QLD Committee of Management

Springtime in Queensland will bring a new Chair, Dr Brett Segal. He takes over following the AGM held on 30th August. Brett has been a longstanding member of the Queensland committee and his practice in Townsville will bring a valuable insight into issues facing our regional areas. The AGM was held as part of the Queensland Committee's celebration of the ASA 90th Anniversary. The invited guests included the President, Dr Mark Sinclair, Queensland's Past Presidents and Honorary Life Members and ASA members that had contributed to the society for more than 25 years. It was also an opportunity to hand out certificates to our 50-plus year members.

Our Queensland trainees have been well supported with several exam preparation events and our recent Part 3 course in Brisbane on August 17th. Special Thanks to Dr Louise Rafter and Dr Lachlan Fairley who organised the event and to all those that contributed their time to give lectures and advice. Our principle sponsors Avant and Walshs Financial add their support and information as trainees step into consultancy.

Several key issues are of special relevance to the Queensland membership. These include recent updates to QScript legislation, the ongoing workforce shortage issues around regional areas, the inadequacy of Surgery Connect (public hospital patients managed in the private sector) remuneration in the light of ever-increasing inflation and cost of practice, task substitution with nurse sedation practices gaining some encouragement following the updated PS09 document, and the new issue of Queensland Government support for Physician Assistants.

QScript

As of July 1, 2024 changes to the Qscript look-up and Monitored Medicines standard requirements came into effect. These changes now provide an exemption for looking up QScript in several circumstances including in-hospital episodes of care. The exemption does not cover the requirement for checking QScript when writing discharge scripts. Given that the legislation has now matured, we encourage members to register and comply with the QScript legislation. Significant penalties may apply for failing to check QScript. The process of checking Qscript remains challenging at times but often has surprising results.

Queensland Surgery Connect

There has been quite a lot of Surgery Connect activity being performed around the state, with 24000 cases outsourced to private care. At the time of writing this report, Queensland Health Minister Shannon Fentiman announced a $100m boost to progress the Surgery Connect program. The variability of remuneration determined by each facility continues to be a significant issue. With inflation and cost of living pressures increasing, I encourage everyone participating in Surgery Connect to raise the issue at craft meetings and negotiate appropriate remuneration and conditions using the ACCC exemption process if required.

Workforce

Workforce issues are challenging the whole country and the world. I'm certain that the issues of overseas trained specialists, nurse sedationist's and now physician assistants have been highlighted in recent newsletters and by our professional subcommittees. Queensland Health released the document on physician assistants' clinical governance guideline dated May 2024. Implementation could affect many areas affecting training, reduced funding, and service delivery. They will require a medical supervisor to oversee their scope of practice (which may have medicolegal impacts), and currently cannot be registered with AHPRA, not recognized by under Medicare benefits schedule or the pharmaceutical benefits schedule so are limited to public sector roles in primary, emergency and preventative care. Cost effectiveness for the role is yet

to be demonstrated. Following negative feedback by medical bodies regarding the scheme and questions by the Courier Mail, Minister Fentiman "binned" the scheme.

Our workforce issues require long-term changes, from increasing training numbers, state and federal funding models that encourage regional participation and support the Hospital and Health Service (HHS), regional anaesthetic service delivery for both public and private practice with modification of 19AB exemption and VMO participation in the regional HHS. Overseas trained specialists are important for regional service delivery determined by the current process and not a government-bypassed system that is currently being proposed.

Thank you to all the members of the Queensland committee for their support and efforts over the two years of my time as Chair. I wish Brett all the best as he takes over in the role. Please continue to support the ASA and encourage membership as we need to preserve the speciality for the next generations and continue to fight the headwinds from government, health funds, and hospital organisations. I look forward to seeing you in Darwin for the NSC.

South Australia / Northern Territory

Dr Tim Donaldson

Chair of the South Australia / Northern Territory Committee of Management

Support

The ASA has made significant strides in strengthening its ties with the Australian Medical Association (South Australia) (AMASA). Through the AMA, we have gained access to crucial conversations with the South Australian government, most recently in relation to payroll tax. This development is a vital step towards better conveying the complexities and structure of anaesthetic practices in South Australia. By being involved in these discussions, we can ensure that the unique aspects of our profession are accurately represented and considered in policy decisions and allow our members to proceed with confidence.

Represent

We extend our heartfelt gratitude to Sophia Bermingham for her tireless efforts and outstanding leadership during her tenure as the SA/NT ASA Chair. Sophia's dedication and commitment have been instrumental in advancing the interests of our association and its members. As she embarks on a new chapter in her career in Singapore, we wish her all the best and look forward to hearing about her future successes. Moving forward, Dr Nicole Diakomichalis will be stepping into the role as Chair in 2025, we welcome her and her enthusiasm in this new position.

Education

A special thank you to Mila Sterbova, Evelyn Timpani, and Krushna Patel for their hard work in organizing the recent trainee dinner. Their efforts provided a valuable opportunity for trainees to network, learn, and grow within our anaesthetic community.

As we celebrate the 90th anniversary of our association, we reflect on the rich history and achievements that have brought us to where we are today. This milestone is a testament to the dedication and passion of our members over the decades.

We are also excited about the upcoming National Scientific Congress (NSC) in Darwin, September 6-9. It will be a fantastic opportunity to catch up with colleagues and continue our professional development. We extend our thanks to the South Australian convenors, Brigid Brown and Indy Lin, along with the entire organising committee, for their hard work in what promises to be an excellent event. We look forward to seeing everyone there and celebrating our shared commitment to excellence in anaesthesia.

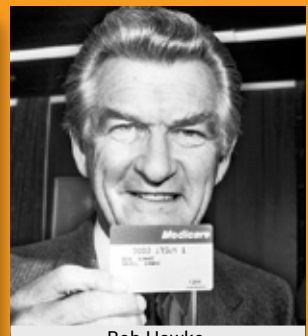
1984 - 1993

A DECADE OF ADVOCACY, AID, AND EDUCATION

Explore a decade defined by advocacy, aid, and education within the Australian Society of Anaesthetists (ASA). This period was characterised by significant medico-political challenges, impactful overseas aid initiatives, and a steadfast dedication to public education efforts.

Medico-Political Advocacy

The introduction of Medicare in 1984 revolutionised healthcare in Australia but brought immediate challenges for anaesthetists. The ASA played a pivotal role in advocating for fair remuneration and working conditions, particularly during the NSW Doctors Dispute in 1984-5. The ASA's efforts led to improved negotiation with the government and advancements in healthcare practices.



Bob Hawke
Photo by David Bartho,
The Sydney Morning Herald

The Harry Daly Museum

The ASA's Harry Daly Museum underwent significant developments during this decade. It relocated to the Anaesthetic Department at Royal Prince Alfred Hospital in Sydney in 1986, expanding its collection and activities. The museum's efforts to preserve and showcase the history of anaesthesia in Australia were highlighted through various initiatives, including the publication of historical materials and the acquisition of significant artifacts.

Overseas Aid Initiatives

The ASA's dedication to global anaesthesia care was exemplified this decade through impactful overseas aid initiatives. The establishment of the ASA's Action Fund Subcommittee in the South Pacific ensured meticulous monitoring and support for critical initiatives like the Portex/ASA South Pacific Study Award. The formation of the ASA's Overseas Aid Subcommittee in 1987 further solidified these efforts, overseeing the distribution of essential support and resources to countries facing significant healthcare challenges.

Public Education Initiatives

The ASA's public education efforts were enhanced during this decade. Initiatives such as the production of patient information booklets and support for tobacco advertising restrictions demonstrated the ASA's commitment to increasing public awareness of the vital role of anaesthetists. These efforts aimed to shape an informed perception of the profession and promote patient safety and well-being.

Membership Growth and Professional Development

ASA experienced steady membership growth throughout the decade, reflecting the profession's increasing recognition and engagement. Efforts to enhance liaison between anaesthetists and the healthcare industry were evident in the formation of joint committees, research awards and prizes, which underscored the ASA's commitment to fostering research and innovation within the field. The establishment of the President's Award in 1992 further solidified the ASA's dedication to recognising outstanding contributions and promoting excellence in anaesthesia. This decade, in 1988, also saw the ASA win the bid to host the World Congress of Anaesthesiologists in Sydney in 1996. Winning the bid to host the Congress marked a significant milestone in Australian anaesthesia history.

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1984 - 1993.

This poster was developed by the History of Anaesthesia Library, Museum and Archives Committee (HALMA) of the Australian Society of Anaesthetists

1994 - 2003

A DECADE OF PROGRESS

This decade was highlighted by the World Congress, unprecedented advocacy directly with Federal Ministers and an effort to improve the public's understanding of the role of anaesthetists.

The World Congress

This decade saw the largest medical congress in Australia hosted in Sydney, the World Congress of Societies of Anaesthesiologists in 1996. With 10,000 attendees, it left an indelible mark on the ASA's legacy, generating a surplus that fortified the society for the years to come.

Elevating Public Relations

Public relations took centre stage to increase awareness of the vital role of anaesthetists in Australia. Initiatives like Informed Financial Consent, the creation of patient information brochures, and the introduction of a National Anaesthesia Day became a symbol of the ASA's commitment to shaping an informed perception of the profession.

Advocacy for the Profession

The ASA's persistent advocacy efforts led to a number of successes for the profession including the integration of the Relative Value Guide into the Medicare Benefits Schedule. These efforts also led to improved payments for anaesthetists caring for veterans and a significant 50% increase in the Australian Medical Association suggested anaesthesia fee.

Restructuring for Future Success

In 1998, the ASA underwent a significant restructuring, replacing the Executive Committee with a Federal Council. This shift, coupled with strategic headquarters expansions, paved the way for continued growth, reflected in increased membership and financial stability.

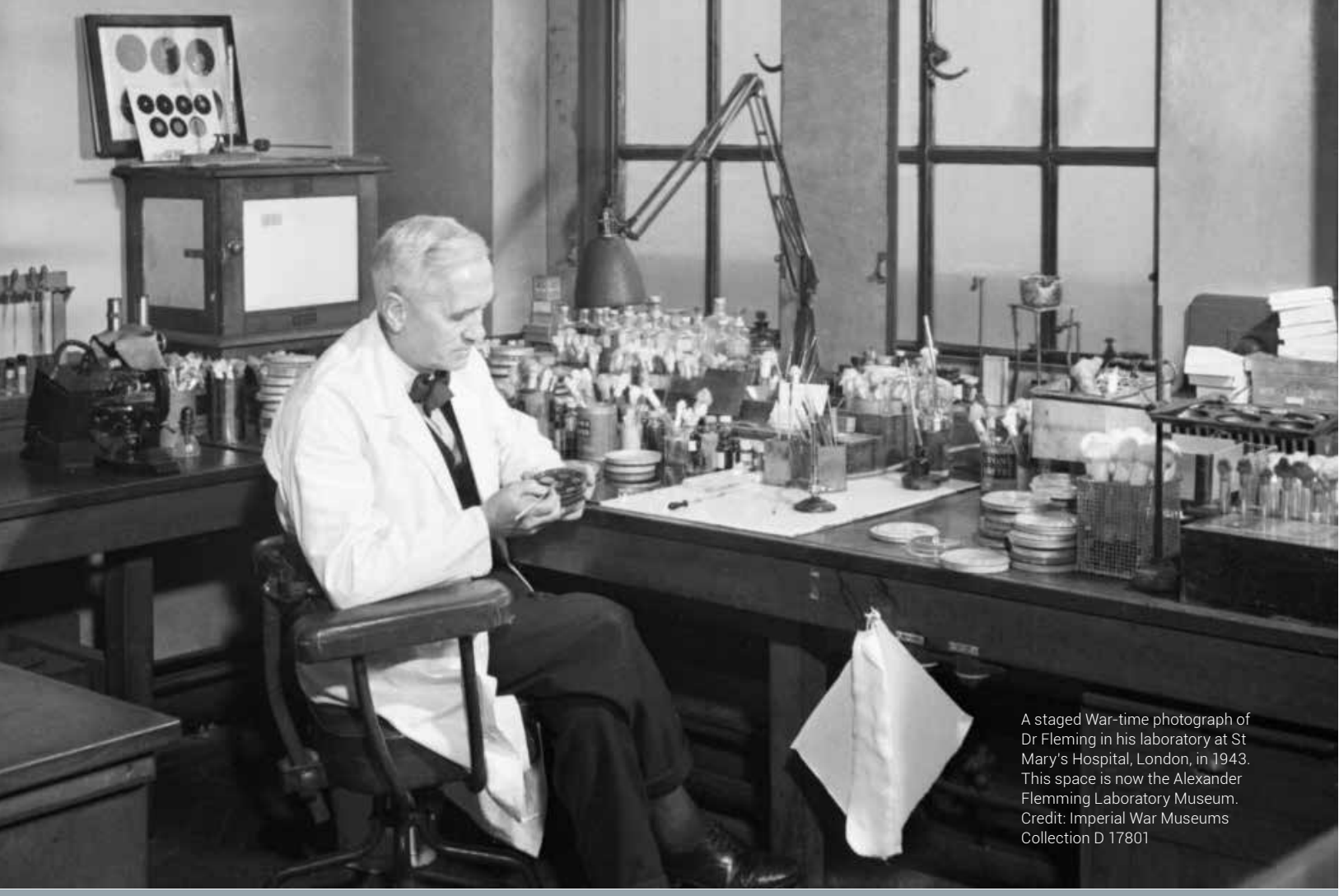
Navigating Medical Indemnity

As medical indemnity challenges surged in the early 2000s, the ASA actively engaged, playing a pivotal role in negotiations with the government, insurers, and legal entities to address the escalating crisis.

Looking to learn more?

Discover more about the evolution of the Australian Society of Anaesthetists across 1994 - 2003.

This poster was developed by the History of Anaesthesia Library, Museum and Archives Committee (HALMA) of the Australian Society of Anaesthetists



A staged War-time photograph of Dr Fleming in his laboratory at St Mary's Hospital, London, in 1943. This space is now the Alexander Flemming Laboratory Museum. Credit: Imperial War Museums Collection D 17801

PIONEERING PENICILLIN

A close focus on an item from the collection of the Harry Daly Museum: an early box of the medical miracle and an early example of penicillin being manufactured here in Australia.

AMONGST THE SLIGHTLY CROWDED DRUGS CABINET OF THE HARRY DALY MUSEUM IS A SQUARE YELLOW BOX, A BIT WIDER THAN YOUR HAND SPAN. IT IS LABELLED *SPECIAL PRODUCT: PENICILLIN, "COMMONWEALTH"* IN A NICE, CLEAR BLUE PRINTED FONT, BUT IT IS THE DATE FURTHER DOWN ON THE LEFT-HAND CORNER THAT ALWAYS CATCHES MY EYE, 'KEPT UNDER SUCH CONDITIONS THIS PRODUCT WILL REMAIN FULLY POTENT UNTIL JUN 46'.

Along with anaesthesia and germ theory, one of the other core leaps in modern medicine was the development of antibiotics. Penicillin, of course, being the cornerstone of that saga.

The story of the wonder drug began in September 1928, almost 20 years before our box, in a small office in Paddington, London. It was the laboratory of Dr Alexander Flemming, whose name is probably well known to our members (and high school students doing science projects on his discovery). Flemming was a brilliant medical student, being awarded the University of London Gold Medal in 1908 for his studies. He had initially wanted to be a surgeon, but a lack of available post-graduate placements led him to accept a job with Sir Almroth Wright's Inoculation Department at St Mary's, working on early vaccines to cure disease.

Flemming had already researched the role of antiseptics in military hospitals during World War I in Boulogne (finding that strong antiseptics actually impaired the body's ability to heal, by destroying white blood cells). In 1921, he discovered the body's own antiseptic, lysozyme. But it was in September 1928, after returning

A ceramic fermentation vessel used during the Oxford research to mass produce Flemming's 'mould juice'. Credit: The Science Museum UK, Collection 1976-628

Senator Fraser (Commonwealth Minister for Health) showing the Mr. Calwell (Minister for Information) dose of penicillin, from the first batch of the drug manufactured at the Commonwealth Serum Laboratories in Victoria, Australia, during WWII. Credit: Australian War Memorial Collection 16689

from a holiday, that he made a Nobel Prize-winning discovery: a petri dish of Staphyloccocci in his lab had become contaminated with a fungus which was inhibiting the growth of further microbes. Initially calling it 'mould juice', it would in the coming months and years of research, be renamed Penicillin notalum.

You can actually visit the very laboratory where medical history happened! I was fortunate enough to serendipitously stumble across it during a recent trip to London. The Alexander Flemming Museum opened in 1993 and features a reconstruction of Flemming's laboratory as it was on that day in 1928, in the very room penicillin was discovered. Flemming's desk, chair and equipment have been arranged from archival photographic references. Upstairs is a small theatre showing a short film on Flemming and his work, as well as an exhibition contextualising the story. You are greeted by a volunteer or the Curator for a short tour. While photographs are not permitted, you can download the digital guidebook.

Flemming worked in this small light-filled room from 1919 until 1933, when he moved to a more modern laboratory. The laboratory in Paddington was then turned into the on-call bedroom for midwifery medical students (which I would presume helped preserve some of the Flemming era design and paint).

Of course, the story of penicillin was not an overnight success. After publishing an initial research paper, and lacking the facilities and other research skills needed to make the mould into an antibiotic, Flemming moved on… until a decade later when Oxford researcher, Dr Howard Florey thought Flemming's penicillin showed great potential.

Florey, an Australian pharmacologist and pathologist with a talent for obtaining research grants, and Dr Ernst Chain worked with Flemming to develop the drug. With the outbreak of World War II in 1939, the need for and value of the drug increased, becoming a national priority to support the War Effort. The UK's Prime Minister Winston Churchill even noted the extreme importance of developing any and all supplies, as well as improving the efficiency of the drug. But there were difficulties in scaling production of penicillin, so Florey and his assistant researchers were dispatched to the USA to help develop techniques which eventually meant supplies of the drug were finally sent to the military hospitals of the Allies in Europe in 1944.

In 2018, the 'Penicillin Papers' were discovered in the basement of The Children's Hospital at Westmead, Sydney, indicating that perhaps one of the first early administrations of penicillin in Australia was in July 1943. The collection of telegrams and letters documented the acquisition of penicillin directly from the defence forces of the United States to experimentally treat 7-year-old Peter Harrison's severe case of meningitis.

The drug was still not available to the general public until after World War II. Naturally, the story of the war-winning drug, the miracle that meant one in four patients might not die of infection, that simple cuts and scrapes not might lead to painful death, captured the imagination and morale of the public. It was also handy for war time propaganda, and the post-war reconstruction period.

Which brings us back to our yellow box, with the best before date of June 1946. Clearly, an early batch of penicillin manufactured in Australia at Royal Park in Victoria, probably made in late 1945 or early 1946, as Flemming, Florey and Chain received their joint Nobel Prize for Medicine on 10 December 1945. Certainly, the Commonwealth Serum Laboratory was manufacturing penicillin for Australian Troops in Papua New Guinea from March 1944.

Penicillin as not the end of the story – it was the beginning of a new and essential branch of medicine. Even at the time of his initial research into the 'mould juice', Flemming and his assistants recognised that certain bacteria were resistant to it, but this led to the search for, and development of, other antibiotics included streptomycin and the cephalosporins.

Kate Pentecost

ASA Museum Curator,
Archivist and Librarian

KENNETH JAMES WILLIAMS

1939–2023

Ken was born in Brisbane in 1939 into a legal family. He was educated at Nudgee Junior and Nudgee Senior before studying medicine at the University of Queensland in 1958 and graduating in 1963.

It was during the university years that Ken's keen interest in golf and lifelong friendship with Dr John Hains (past president ASA) developed. Occasionally local golf tournaments would distract from the lectures! Intervarsity golf events included trips to Sydney and Melbourne.

Ken commenced anaesthetics training in 1965, married Penny, and started his family (ultimately four children) all about the same time. They moved to Melbourne to work at the Melbourne Children's Hospital under the leadership of Dr John Stocks, whom Ken greatly admired. He also appreciated the availability of anaesthetic equipment which was lacking in the Brisbane public system at the time. He joined the ASA in 1966.

Ken obtained his Australian Fellowship and was offered a place in a Brisbane private group in 1970. The group had been established by Dr Roger Bennett and Dr Dan Hogg in 1962 and was known as RA Bennet and Associates, and later Dan Hogg and Associates when Ken joined. Ultimately the group would become known as Narcosia Anaesthesia. The group would include Dr Dan Hogg, Dr Peter Livingstone, Dr Barrie McCann, Dr Wally Biggs, Dr David McConnel and his old friend Dr John Hains who would join a year later. Ken became the chairman of Narcosia when private anaesthetic practices were beginning to deal with issues of payroll tax and corporate governance.

Ken was Visiting Medical Officer at the Princess Alexandra Hospital in Brisbane from 1970 to 2001. He was involved in teaching registrars and did two trips to the Anaesthesiology Centre for the Western Pacific in Manilla as a visiting lecturer in 1977 to 1978.

He acted as Chairman of the department which involved chairing the bimonthly departmental meetings on a Tuesday night for three years in the late 80s. Ken's no-nonsense approach to teaching and these meetings kept the registrars on their toes and the meetings running efficiently.

Boats and the Moreton Bay became a passion for Ken from the mid 60s. Initially it was his in-laws' boat that attracted him to life on the water, but he soon had his own boat which became his pride and joy. Fishing and fishing trips, boats and boat maintenance, golf and his family occupied Ken's time once he retired from practice in 2002.

In the end, an episode of Covid in addition to some frailty in his final years led to his passing on the 29th November 2023.

As a 50-plus year member of the ASA, Ken influenced public and private anaesthetic practice in Brisbane by striving for high standards of clinical practice and training, and bringing his entrepreneurial and business skills to private practice.

Dr Graham Mapp

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